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CANADIAN THESES ON MICROFICHE

THÈSES CANADIENNES SUR MICROFICHE

NAME OF AUTHOR/*NOM DE L'AUTEUR* BLAKE, ELIZABETH ANARYE

TITLE OF THESIS/*TITRE DE LA THÈSE* Negotiating Health and Illness: an Inuit Example

UNIVERSITY/*UNIVERSITÉ* The University of Alberta, Edmonton, Alberta, Canada

DEGREE FOR WHICH THESIS WAS PRESENTED/ *GRADE POUR LEQUEL CETTE THÈSE FUT PRÉSENTÉE* Ph.D.

YEAR THIS DEGREE CONFERRED/*ANNÉE D'OBTENTION DE CE GRADE* 1978

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THE UNIVERSITY OF ALBERTA

Negotiating Health and Illness: an Inuit Example

by

© Elizabeth Anarye Blake

A THESIS
SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE
OF DOCTOR OF PHILOSOPHY

Department of Anthropology

Edmonton, Alberta
Spring, 1978

THE UNIVERSITY OF ALBERTA
FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled NEGOTIATING HEALTH AND ILLNESS: AN INUIT EXAMPLE submitted by Elizabeth A. Blake in partial fulfilment of the requirements for the degree of Doctor of Philosophy in Anthropology.

Regna Darnell
Supervisor

External Examiner

Date. October 23, 1976

DEDICATED TO THE MEMORY OF

Ruth Hawkins Blake

and

Eugenia "Ikie" Harris

Negotiating Health and Illness: an Inuit Example

Abstract

Elizabeth Anarye Blake

It is generally believed that contact between cultures at the Band level of social organization with those of the Nation-State is typified by adaptation on the part of the subject culture or, failing to do so, by becoming dependent upon the dominant culture for their survival. In view of data gathered in a small Inuit village on the northeast Labrador coast, which focussed upon the handling of health and illness within the community, it is argued here that neither adaptation nor dependence is the only structural alternative available when contact occurs between cultures organized at polar levels.

After a period of 200 years of contact, the traditional social structure of the Inuit has not only been sufficient to thwart many of the efforts of the dominant culture to change their social organization, but has initiated, in fact, the form that interaction would take between the two: the creation of a social network between important persons from each social group whereby the outcome of matters affecting the community are negotiated. In more recent years the power differential increasingly operates in favor of the Whites, however, and the deterioration of the social network which allowed the subject population some degree of autonomy has now become substantial. It is a question now whether this heretofore effective social mechanism through which Inuit guided events crucial to the maintenance of cultural identity will be brought to an end.

Preface

Various techniques are available to the social scientist to ensure that unnecessary embarrassment or personal social costs will not be borne by individuals or communities studied once material is made public. I am aware of these methods and have used them to obfuscate the identity of many individuals in the community of Nain, Labrador who appear in this thesis. There is a decision that must be made by the researcher, particularly in studies that deal with personal interaction and case histories, to what extent he will candidly portray roles he sees to be necessary to an understanding of the underlying principles that operate in a given domain.

The high rates of illness and disease among the Inuit population of Nain were seen by me to warrant a more than ordinary open treatment of data, identifying accurately those roles directly related to the handling of health and illness in the community. I want to stress that I am at all times addressing myself to the role, not the person who happened to occupy the role during the period of time in which I undertook fieldwork. No blame is placed on any individual for the conditions that exist in Nain, since these conditions are a historical product and, as such, exist independently of the particular person who occupies a given role at a specific point in time.

As sensitive as the material is that forms the body of the thesis, I take full responsibility for its inclusion and manner of presentation. I believe that only by laying bare the realities that transpire when individuals with roles of power interact in a domain like health will there be an opportunity for improvement. Nain's Inuit citizens are in great need of an effective health care program. A more oblique handling of the events and conditions surrounding health in Nain at the time of fieldwork would do little to contribute to fulfilling this need. Failure by the dominant culture in Nain to understand Inuit regulatory principles in both health and social control has resulted in pushing the subject culture to its limits to cope. One objective of this thesis is to demonstrate the conflicting principles that render the dominant culture's health delivery system ineffective and suggest alternative techniques whereby it can make a relevant contribution to the subject culture's efforts to continue as a viable culture.

ACKNOWLEDGEMENTS

The belief that personal history and cultural imperatives form the basis of effective medical treatment has motivated the research and writing of a thesis directed toward the particular needs of a contemporary people. However, to arrive at a point where the writing of a thesis is possible has much to do with those who have given direction to one's life.

Francis Underwood taught me the basics of anthropology as my undergraduate advisor at San Jose State University. She has guided me through the ensuing years through the means of an active correspondence as well as editing the final form of the thesis. Marie Reynolds was the first individual to excite my mind about medical anthropology and in doing so established the basis for my specialization. I acknowledge a special debt of thanks to Joseph Hester for teaching me the value of precision. To these instructors I express my gratitude.

Regna Darnell, my major graduate advisor, has helped in ways "small" and "large" throughout my graduate career to ensure that all phases of my training met those standards she held as requisite to the discipline of anthropology. She has served as a model of professionalism and in other ways too numerous to enumerate. I wish also to acknowledge the assistance of other members of my committee at the University of Alberta. I am indebted to David Young, Clifford Hickey, and Michael Asch for their input to the preparation and writing of this thesis. Marilyn Assheton-Smith of the Department of Education Foundations at the University of Alberta, the outside member of my committee, contributed significantly to the final version of the thesis at the time of the defense. I owe a tremendous debt of gratitude to my External Examiner, Luis Kemnitzer of San Francisco State University, for his incisive handling of the material during the defense itself.

I wish to thank the Institute of Social and Economic Research of the Memorial University of Newfoundland, St. John's, Newfoundland, for awarding me the grant which allowed me to carry out research in Labrador. I am grateful to Milton Freeman, Robert Paine and Jean Briggs of Memorial University for preparing me for fieldwork in Nain.

Anthony Vanek has advised and edited the linguistic material throughout the writing of the thesis. I am deeply appreciative for his valuable suggestions. I also wish to thank Albert Heinreich of the University of Calgary for his invaluable assistance in the interpretation of the Inuit orthography. Without the help of Wendell Oswalt of the University of California at Los Angeles, I could not have had access to the UCLA library facilities that was necessary during the latter stages of writing the thesis. And lastly, I am indebted to Julie LeGras for transforming my own rendering of the Nain town plan and charts to the excellent form in which they appear in the thesis.

I owe a special debt to several individuals for their friendship and moral support throughout my graduate career: James and Wendy Birckhead, the Hugh Patrick Macdonald family, Klaus and Val Schleindl, Roy Piepenberg, Eleanor Williams, and Paul Fitch.

There are some to whom I owe more than an acknowledgement, people outside the realm of academia and fieldwork, but nonetheless were antecedent to these activities. I wish to express my gratitude to Helen and Winfield Wagener for creating the circumstances which led to my continuing education, and then helping me to convert these circumstances into reality.

I am grateful to my father, Verdie Blake, and to my sister, Patsy Anderson, for their quiet support during these years. I was unusually fortunate in that my daughter, Andrea Snodgrass, not only understood my objectives, but happily sacrificed certain expectations of her own in order that my studies not be interrupted.

I want particularly to acknowledge my debt to the community of Nain. It was my good fortune to live in the home of Eugenia "Ikie" Harris, the native healer, and her husband, Ame. I was spared many problems due to this arrangement and learned through this close relationship in a way which would otherwise have been denied me. "Ikie" crossed the cultural boundaries and transferred to me much of the knowledge she had acquired through caring for the health needs of her people. Her death from cancer one year after I left the field attests to the effort required to convey this invaluable information.

My sincerest thanks are extended to Gilbert Hay, a young Inuit man who was my research assistant while in Nain. He accompanied me back to my resident university where he attended a special school in Edmonton for two years. His continuing assistance allowed me to come to terms with the material in a way that I could not have done otherwise. It gives me great personal satisfaction to know he returned to his village to become Nain's first Inuit Taparisat representative.

I wish to recognize the following individuals in the community of Nain who acted as informants and in many instances became good and valued friends:

Amos Atsatatta
Merium Brown
Mary Daniels
Bill Denniston
Christine Denniston
Christine Dicker
Harriet Dicker
JoAnne Dicker
Ethyl Ford
Rosie Ford
"The Ford Boys"
Joe Fox
Susie Green
Ama Harris
Alice Harris
David Harris
Eugenia Harris
Paul Harris
Linda Harris
George Hay
Gilbert Hay
Mary Hay
Clara Hay
Susan Hay
Peter Hay
Mr. Haynes
Mrs. Haynes
Miss Hettasch
Jeanie Ikkusik
Miss Jupp
Justine Kelleo
William Kelleo
Adam Lidd
Sabina Lidd
Ben Ludlow
Bella Lylle
Jim Lylle
Regina Lylle
Sue Martin
Martin Martin
Sam Metcalf
Paulus Nakasak
Appia Obed
Doris Obed
Ellius Obed
Lizetta Obed
Mickey Obed
Rosie Obed
Jane Obed
Dick Pomak
RCMP Constable Conrad
Mary Sillit
Jerry Sillit
Sam Soloman
Mark Suksagiak
Joe Tuglavina
Edward Voisey
Douglas White
Lizetta White
Henry Webb
"Old" Noah & his wife

TABLE OF CONTENTS

Chapter Page

I. OBJECTIVES OF THE STUDY 1

Introduction 1

Units of Analysis 3

The "negotiating collectivity" 6

Breaching Episodes 11

Situation, Event and Setting 12

Features of Cognitive Diversity 14

Inuit System 15

General Differences Examined 20

Discussion of Cognitive Diversity 26

Summary 33

Organization of the Thesis 38

II. CONDITIONS OF FIELDWORK 40

Introduction 40

Entry into the Field 40

Social Group Affiliation 43

Finding Informants 45

Collecting a Corpus of Disease/Illness Terms . 47

Sorting and Assignment of Terms 49

Other Methodological Techniques 52

Chapter Page

Techniques for Identifying Social Group Boundaries 52

Additional Verbal Eliciting Techniques 55

Recording of Behavioural Units 57

Summary 59

III. HEALTH IN NAIN 62

Introduction to Part I: The Healthy Individual . 62

A Definition of Health 62

Manifestations of the Mentally Healthy Individual 65

MaptoneK tange, "Consistency" 66

Ikubliariktovok, "Moderation" 69

Inulinek, "Gregariousness" 72

Degree of Adherence to Selected Traits of Mental Health 74

Manifestations of the Physically Healthy Individual 78

Diet 80

Exercise 83

Physical Health vis-a-vis the Environment . . 84

Introduction to Part II: The Unhealthy Individual 85

Accidents and Violence 87

Respiratory Diseases 89

Other Conditions 90

Summary 94

Chapter Page

IV. HISTORY AND SOCIO-ECONOMIC ORIENTATION OF NAIN'S POPULATION 97

Introduction 97

General Description of the Environment 98

History of Contact 100

The Moravian Period (1771-1871) 100

Fisheries Period (1871-1926) 102

Hudson's Bay Company/Confederation/Division of Northern Labrador Affairs (1926-1972). . 104

Socio-Economic Orientation 107

Socio-Economic Orientation by Group 107

Summary 121

The Two Principals of the "negotiating collectivity" 122

Goals, Means and Attitudes of Each Social Group 127

V. COMMUNITY RESPONSE TO SELECTED EPISODES OF ILLNESS 130

Introduction 130

Illness at the Community Level 135

Venereal Disease 136

Hepatitis Epidemic 146

The Oil Shortage 157

Summary of Community Level Illness 166

Physical Illness 170

Chapter Page

Ellius 171

Simiak 177

Juliana 184

Summary of Physical Illness 194

Mental Conditions 195

Ama 196

Bertha 204

Analytic Framework for "Seeing Things" 207

Summary 214

VI. THE EFFECTS OF THE "NEGOTIATING COLLECTIVITY" ON COMMUNITY STRUCTURE 218

Introduction to Part I: Ideological and Historical Background of White Administrators 218

Moravian Ideological Principles 218

The IGA's Ideological/Historical Background . 222

Summary of Part I 227

Part II: Ideological Background of Inuit-Settler/Inuit 228

The Effects of "Social Work" by the "Negotiating Collectivity" 231

Summary 235

Chapter Page

VII. SUMMARY AND CONCLUSIONS 238

Introduction 238

The Future of the "Negotiating Collectivity" . . 238

Conclusion 240

BIBLIOGRAPHY 241

APPENDIX 1. THE ORTHOGRAPHY 249

APPENDIX 2. TAXONOMY OF ILLNESS 257

APPENDIX 3. NAIN SITE PLAN 258

LIST OF TABLES

Table	Description	Page
I	Inuit Traits of Mental Health Contrasted by Social Group	76
II	Class Participation in Subsistence Activities	121
III	Kinship Affiliation of Curer with Roles of Authority	126
IV	Breaches Involved in Venereal Disease	144
V	Breaches Involved in Hepatitis Epidemic	155
VI	Breaches Involved in the Oil Shortage	164
VII	Breaches Involved in Ellius' Case	175
VIII	Breaches Involved in Simiak's Case	182
IX	Breaches Involved in Juliana's Case	190
X	Breaches Involved in Ama's Case	202
XI	Breaches Involved in Bertha's Case	206

LIST OF FIGURES

Figure	Page
1. Caribou Hunting Areas	111
2. Sealing Distribution	112
3. Summer Fishing Distribution	113
4. Assessment of Community Level Negotiation	167
5. Approximation of Cognitive Processes	209
6. Approximation of Evaluation of Events vis-a-vis Ethos	211
7. Approximation of Rationale in weighting Social Events	212

OBJECTIVES OF THE STUDY

CHAPTER ONE

I. INTRODUCTION

All people experience illness and organize behavioural strategies or practical techniques to deal with it. Although illness is universal, anthropologists have long been concerned with the fact that man's perceptions of and responses to illness vary greatly depending on the cultural context in which they appear, e.g., Wallace 1970: 200. Cultures differ considerably with regard to their evaluation of what it is to be sick; therefore, conditions which are seen as inconveniences in one society may create incapacities in another. At one level, illness is a physical process, but it is always dealt with by culture-specific categorization.

Illness is neither static nor a distinct entity; it is defined by a culture-specific configuration of ideas, whose special meaning derives from the history and ongoing social life of a particular people at a given moment in time. It is the purpose of this study to describe the methods of handling of illness by members of the community of Nain, Labrador, through an examination of some of the health-related events that affected members of the community during the course of my fieldwork, and to provide an abstraction of general processes underlying handling of these particular events.

Any ethnographic category may be used as a focal point to exemplify general processes that operate in a society. I am interested in health, consequently I have restricted myself to describing the decision-making processes surrounding health and illness. The general decision-making processes could have been explored with reference to any other significant domain. For example, the most salient fact of Nain social life is the power differential between the Inuit and White segments of the community as it gives a dynamic force to decisions relating to health matters and explains, indeed, why extensive negotiation between Inuit and Whites is necessary in specific episodes of health and illness. The realities of cultural retrenchment, economic exploitation, limited access to resources, etc., are also directly related to health, but it is not the purpose of this thesis to explore them in any detail.

There are four social groups that go to make up the 650 individuals who reside in Nain that result in multiple conceptualizations regarding health and illness. There were two major conceptual domains in Nain represented by four different social groups, two of which held the Inuit notion and two of which held the White one.

The essential attributes of each group are briefly presented below. The categorical terms are used by members of the groups to describe themselves, with one exception. I created the term "Inuit-Settler" (these are not distinguished from other Inuit in Nain) to correspond to social and behavioural distinctions that separate the long-term residents of Nain from those Inuit who have more recently been relocated there from northern Labrador.

1. Whites are EuroCanadians who constitute personnel of outside agencies with economic, religious and administrative positions in Nain. Obviously, these need not be racially "White."
2. Settlers are the descendants of North Europeans who have resided with and married into Inuit families for almost two centuries along the Labrador coast.
3. Inuit-Settlers are those Inuit who are long-term residents of the Nain area, families whose ancestors were, in many instances, native to this area prior to contact.
4. Inuit are those individuals who were relocated from more northerly communities of Labrador to Nain just before and after 1959.

Specific behaviour, attitudes, and cognitive structures dealing with illness will be differentiated first by group membership, and then by other variables, i.e., role, sex, generation and the like.

When illness is discussed within the framework of meaning and action for the residents of Nain I take the emic perspective. Since illness in Nain is also a pervasive fact of life as it would be defined by western medicine, the etic perspective is utilized when illness is discussed at this level. The thesis' focus is emic, but for reader understanding the etic view of the kinds and rates of illness reported by representatives of western medical personnel stationed in Nain are seen to be important as well.

II. UNITS OF ANALYSIS

It cannot be assumed that our frames of reference used to define semantic domains such as illness or kinship are cognitive sets for other populations, nor can it be assumed that units of analysis that are applicable in one society will be valid when applied to another society.

The extent to which specific domains are salient must be determined in every case. For this reason, I initially verified the existence of illness as a "salient domain," i.e., "What the significant social categories are (for the population under study) not... what they ought to be" (Leach 1961: 27). It was conceivable that illness might have been largely subsumed under another domain, e.g., hysteria, fainting, coma, involuntary movement of the limbs, and the like are not perceived as illness when they occur in particular religious contexts. In fact, the handling of illness in Nain often relegates purely medical priorities to a secondary role vis-a-vis social, religious, or economic priorities.

All methods available to the cognitively oriented anthropologist lead to the conclusion that there are two distinct cognitive systems concerning illness in Nain. The existence of cognitive diversity, its distinctive features (particularly amongst the Inuit/Inuit-Settler segments of the community), and the ways in which such diversity was managed was determined by the use of analytical units such as those derived from Cognitive and Interactional Theory.

Cognitive theorists see meaning to reside in the categories and shared rules of individuals. One technique cognitive theorists use to elicit these rules is Componential Analysis, a method of descriptive semantics which elicits internal evidence (of procedures followed by speakers) when classifying segregates into specific lexical domains. It is a process by which a matrix of variables intersect to form the accepted meaning of a word for a particular speech community. This is the core of the most general definition of componential analysis; however, some componential analysts claim no psychological reality, e.g., Lounsbury 1964: 212-231.

Whereas I had started looking for a single taxonomy by techniques associated with componential analysis, I found it to be unproductive with respect to my objectives because informant classification principles that could be replicated with accuracy did not exist (Asch 1972: 9), nor did componential analysis provide procedures to correlate informant terminology and informant behaviour or generate rules to exemplify general processes. Associated with these inadequacies, I was faced with the problem of accounting for boundaries between the various social groups I encountered, and had in some way to explain the wide range of cognitive variation to be found within each social group. Most crucial, however, was the mounting evidence that it was behaviour and not labelling that accounted for certain dimensions of the illness domain. Specific social-cultural imperatives are associated with each disease/illness syndrome, and if such imperatives are analyzed by means of the "social work" (see pages 127 and 231-237) that accompanies each event, the underlying general processes by which a society makes decisions becomes accessible.

My own use of componential analysis was consequently restricted to the elicitation of the native taxonomy as a heuristic device whereby informant categorization and the inner correspondences between categories might be used as a cross-check against findings obtained through other techniques.

In order to account for both behaviour and social-cultural imperatives associated with illness in the community, a change in strategy was indicated. My objective was a study of the decision-making processes relating to health, hence, I had first to demonstrate the ethnographic structure of the village of Nain, and, secondly, my theoretical and methodological orientation had to become more interactional.

People have knowledge about health and illness; the behavioural output of that knowledge is both verbal and non-verbal. Thus, it is an interactional reality -- not a reality that can be accounted for by semantic analysis alone.

Major units of analysis that were used to demonstrate the interaction that ensued between individuals in Nain when faced with illness are examined on the following pages.

A. The "Negotiating Collectivity"

During the initial weeks of fieldwork it became apparent that in actual situations involving illness, the questions of "What to do?" were often not so much the decisions of persons who were ill, but those of certain key individuals who hold power in the village (although not as a unified group) who negotiated the outcome of the situation. These people I have designated as a "negotiating collectivity" (pages 6 thru 11 outline the essential characteristics of the collectivity; further elaboration is found throughout the thesis with material of special relevance appearing on pages 214-217 and 231-237). These individuals are from various segments of the community and it is their decision to act or not to act that determines what will be done about particular episodes of illness.

These specific individuals acted to weigh the consequences of illness upon the community; some from the perspective of its effect upon the patient, some from the effect upon the economy, and among the Inuit community sickness was evaluated as a social regulating mechanism. Sickness was evaluated from still other perspectives which indicate the social-cultural range incorporated in the decision-making process. These key individuals came from each social group in the community and were instrumental in mobilizing the energies of the various social groups to effectively deal with illness in Nain.

Interestingly, each key person held, without exception, an important role in the village; these roles had nothing to do with illness except in two instances, i.e., the International Grenfell Association Nurse and the Akiterijuq, "native healer." Chapters four and five will explore the nature of these roles, and the means by which such multiple allegiances were handled when actual situations of illness defied normal procedures. These key persons and their social groups are listed on the following page:

(White)

The Division of Northern Labrador Affairs (DNLA) Store Manager
The Division of Northern Labrador Affairs (DNLA) Fishplant Manager
The Moravian Minister
The Moravian School Principal
The Royal Canadian Mounted Police (RCMP) Constable
The International Grenfell Association (IGA) Nurse

(Settler)

"Head" of the Community Council of Nain

(Inuit-Settler)

The Akiterijuq, "native healer"
"Former" Head of the Community Council of Nain
"Chief" of the Moravian Church Elders
"Former" Chief of the Moravian Church Elders
The Caretaker of the Dead
Inuit Taparisat Representative of Nain

(Inuit)

The Royal Canadian Mounted Police (RCMP) Special Constable
The Angakok, "Shaman"

(Honorary Member)

Anthropologist (during the period of fieldwork and in a restricted form)

Note: The initials indicated by parenthesis in the foregoing list will be used throughout the thesis to refer to such agencies and/or their agents.

From this decision-making core of individuals flow the lines of power and influence through which a diverse society with a broad range of cognitive perceptions toward illness was managed, if not consolidated. Since I found through the elicitation of the taxonomy (for Inuit-Settlers and Inuit) and medical histories, life histories, and participant-observation for all key members, that these key persons held concepts toward illness that differed from at least some of those with whom they arbitrated, the activities in which they engaged resembled that of a "negotiating collectivity" (Blumer 1972: 80-82), i.e., a general network of actors who interact around health issues, as well as other types of issues in the community. Blumer's definition of a "negotiating collectivity" has been modified to reflect the more fluid composition typical of Nain's particular "negotiating collectivity."

The "negotiating collectivity" does not act as a unit. Those who act are some situationally-determined portion of that collectivity. Each member of the collectivity represents a constituency. Constituency refers to White, Settler, Inuit-Settler or Inuit social groups, or some temporary admixture of one or more of these groups depending upon the issue under negotiation. The collectivity could not exist, in fact, if they fully understood each other. In situations involving the use of resources, for instance, social groups in Nain may well understand the position held by the others. This is not the same as saying they understand the rationale behind those positions. This is crucial to my argument. Inuit often understand the position of western medicine and western medical personnel in certain instances, while not comprehending the rationale behind the position.

Another feature of this collectivity is that proxies do not operate in the absence of a member of the collectivity from the community. Only the role holder has the authority, and usually the necessary knowledge, to arbitrate with other members of the group. In Nain, the basis of authority is personal and situationally restricted. There are, on the other hand, individuals who act as "fronts" for members of the "negotiating collectivity" -- some of these "fronts" are known to the audience, while others are not -- but these people act under distinct instructions of the member with the power in the collectivity. Examples of events wherein "fronts" carry out the business of a member of the collectivity would be the presentation of an issue in the Community Council as illustrated by the following account;

When the "head" of the Community Council acted rudely and arbitrarily toward a woman wanting him to remove building debris from the children's play area, he was publically rebuked in the community council. It was made clear to him that behaviour of that kind would not be tolerated in the future. He had a wide range of behavioural alternatives that were not available to other men in Nain, but he did not have the right to act as he did in that instance; he had been inconsistent in his role. His role was confined to hearing all grievances, whether presented to him personally or in public meetings. If a problem were presented to him personally, it was incumbent upon him to take the matter to others of the council before making a decision. He might argue against any particular issue that he did not personally condone, but he did not have a final vote in any matter. Thus, to have refused the woman's request at a personal level was out of character for his role; his action had far wider ramifications than the matter of clearing debris from the children's play area. Fundamentally, the issue at stake was whether the "head" of the community council had individual powers beyond the council as a collective body. The example cited was presented to the council by a niece of the akiterijuq (while the akiterijuq sat some distance away, apparently dozing). I had been present when the akiterijuq briefed her niece in the way she should state the case to the council.

An example of a known "front" would be the "Former" Chief Elder, who, as everyone knows, is used by the DNLA Store Manager and the Fishplant Manager to present their interests to the people of Nain.

This group of notable individuals undoubtedly comprises the central unit of analysis, demonstrating the all important question of how "social work" is accomplished between members of the collectivity and their constituencies.

B. Breaching Episodes

It was equally important to demonstrate why negotiations were either successful or unsuccessful. By employing the concept of "breaching," this requirement was met. Breaching may be explained in that people attempt to understand each other on the assumption of the reasonableness of the other's statement. In such cases the situation proceeds satisfactorily until a breach (or violation) of one or the other's expectations occurs (Mehan and Wood 1975: 23-27). This is normal to interaction. The "social work" that ensues to correct such breaches is often ineffective, or only partially effective, and rarely leads to structural change. In Nain, where negotiating members' perceptions and objectives were often in conflict, such breaching occurred regularly. By observing incidents of breaching, I was often able to isolate the activities by which the breach was at times transcended and resolutions effected. More importantly, I was able to identify the kinds of breaches that stopped arbitration and resulted in the ineffective handling of health problems. It was the breach that encroached upon what constituted "normal" for either major cultural group that brought an end to negotiation, or precipitated conflict (I did not focus upon negotiation that was successfully arbitrated, for the most part, because I wanted to discover how health and illness were handled in a community where multiple conceptualizations exist and what, in fact, constitutes "normal" for either major cultural group). Effective health care was, in any case, rare and could only be obtained by substantial "social work."

C. Situation, Event and Setting

Units of analysis used other than the "negotiating collectivity" and "breaching episodes," were those of "situation," "event," and "setting" (Gumperz 1971: 291-293; Ervin-Tripp 1965: 86; Sherzer and Darnell 1971: 548-554). Case studies which illustrate the reality of the collectivity will be "social situations" as defined by Gumperz, "...activities carried on by particular constellations of personnel, gathered in particular settings during a particular span of time." Those cases which focus upon the health problems of single individuals as opposed to those effecting the entire village may be more accurately seen as "social events." Gumperz defines "social events" as activities which are centered "...around one or at the most a limited range of topics (and) are distinguishable because of their sequential structure" (Gumperz 1971: 291-293). When "setting" is employed as a unit of analysis, however, I will follow Ervin-Tripp's definition: "...that of locale, or time and place and that of situation," including that "occurring when people encounter one another. Thus, situations include a family breakfast, a faculty meeting..." (Ervin-Tripp 1964: 86), or in the context of this study, when key persons in the community encounter one another for the express purpose of negotiating matters bearing upon health. Ervin-Tripp's definition of "setting" corresponds more closely with the flexible manner in which Inuit themselves perceive "setting." This is because the Inuit/Inuit-Settler's sense of time (that in turn effected a specific event) was often found to differ from that of Whites and Settlers.

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Theoretically I have drawn heavily from interactional theory, but have not followed any specific model of interaction theory explicitly. The aforementioned units of analysis form the theoretical framework whereby the general processes bearing on health and illness in the community of Nain become accessible to the researcher. Each analytical unit is performance based; any theory of competence is necessarily performance-based, since it provides the only way to get at basically social phenomena (Darnell & Vanek 1976: 195-211; Darnell 1975: 1008-1016).

I have not attempted to replicate the cognitive maps of individuals or social groups in the village of Nain or to systematically present the "psychological reality" of illness of persons or groups through a formal taxonomy. The case histories plus the perspectives and actions taken by each member of the collectivity will demonstrate that their performance as arbitors of illness on behalf of their respective social groups is possible through partial equivalence structures (Wallace 1970: 34-35). Particular emphasis is given to the mechanisms through which this is accomplished by attempting to describe what correctness is by those who construct it (Psathas 1972: 212) in focussing upon breaches of correct behaviour.

III. FEATURES OF COGNITIVE DIVERSITY

In order to understand cognitive diversity between members of the "negotiating collectivity" as it effected health matters in Nain the Inuit system for categorizing illness must be comprehended (refer to Appendix II). The fundamental features of the Inuit system for classifying illness are first examined at a specific level. Following that, general differences that operated with regard to health for the two major cultural groups in Nain are presented.

A. Inuit System

Evidence that Inuit-Settler/Inuit held a conceptualization toward health that differed from the White/Settler population was, as stated, initially confirmed through eliciting the taxonomy. The most significant characteristic of the Inuit system for categorizing is its open-endedness (a domain may be highly elaborated and still be open-ended), and in this characteristic lies its capacity for change. No coding rules exist which prohibit the addition of new categories and/or concepts of illness when the need becomes apparent. It is the flexibility inherent in an open-ended system of this nature that has allowed changes to be made in Inuit pathogenisis since contact, so that their concepts of disease causation have come to correspond more closely to those of the dominant culture, at least for certain kinds of illness.

The second essential feature of the Inuit system for classifying illness (see Appendix II) is that each major category is explained by multiple agents of causation in every instance but one -- that of congenital conditions where only non-cultural explanations are found -- since the biophysiological facts responsible for congenital conditions in many instances resemble those of western medicine. This is explained in that mankind can and does arrive at "scientific" answers through nonidentical processes and to the fact that the native healer learned of these relationships during the eleven years she worked in the nursing station at Nain. But in all other illness categories, multiple causative agents are/can be identified in the native diagnostic process. This feature has allowed the continuance of traditional diagnostic techniques which serve as a social regulating mechanism.

For example, conditions associated with *Kauiŋnininit issumuk*, "mental conditions," may originate from either cultural or non-cultural causes in every instance, although cultural explanations are used with the greatest frequency. The category *Kauiŋnininit issumuk*, "mental conditions," more than any other category, was found to serve a crucial integrative social function and to have undergone the least change of any category in the Inuit domain of illness.

Conditions originating in the *Timiluttaq*, "body," on the other hand, are attributed almost entirely to reasons such as improper diet, lack of exercise, over-exertion, and so on. Only in a limited number of bodily disorders is it possible to find cultural pathogenesis; *aniniŋitssaq*, "shortness of breath" and *ipeluaʔllaq*, "profuse sweating," are two such instances. Other major causal categories such as *Pillukok*, "Accident" and *Silamit*, "Environment," include as pathogenic agents poor judgement on the part of man, fate, a curse, moral transgressions, or unavoidable exposure to the elements, but basically tend to be explained along non-cultural lines.

One of the most interesting features of Nain Inuit's classificatory system relates to "ability to function in an unimpaired manner." Conditions like *Kiluluttaq*, "harelip," are classified as an "Annoyance Condition," and subject to no more concern than *Puilliagiq*, "rash." *Tunnuanijuq idluilliajuq*, "hunchback," was, moreover, designated by some informants to be a serious condition, while others dismissed it as an annoying condition. Both designations were correct, because informants had made their assignment on the basis of specific individuals known to them; it was not the condition the informants were assessing, but the degree to which the condition interferred with an individual's ability to perform his normal duties. Thus, informants who classified Tunnuanijuq idluilliajuq, "hunchback," as a "bother" were thinking of someone who, despite his deformity, functioned normally. This emphasis on ability to function also accounts for the classification of quite mild disorders -- from the EuroCanadian perspective -- into categories reserved for serious sickness, e.g., measles and influenza. To the Inuit such classification is entirely justified, since effective immunity to such conditions has yet to be established. As a consequence, illnesses considered by EuroCanadians to be minor may render an Inuit totally non-functional and even lead to death.

The fact that the diagnostic process for many illnesses involves phenomena which are extraneous to the domain of illness from the perspective of western medicine is a fourth characteristic of the Inuit classificatory system that distinguishes it from the White/Settler model. Iugukssaq, "seeing spirits," is an example of this characteristic, in that no less than eight causal agents could precipitate "seeing spirits:"

1. as a retribution for having transgressed against an individual or behavioural code of the community, or the breach of a taboo held sacred by the community.

2. a malevolent spirit, or spirit of the deceased who is merely discontent. Such spirits may be placated by placing a small gift on the grave of the dead. In some cases it becomes necessary to seek the advice of the akiterijuq, who will recommend a more substantial form of appeasement, or a personal taboo to follow in order to be protected from such spirits.

3. a spirit sent to harm someone as a result of a person in the community purchasing the power to direct a spirit, i.e., illiksiniq, "curse." This category of spirits is the most feared and the only avenue open to individuals placed under a curse is seen to be the use of a counter curse.

4 and 5) a familiar of a healer or shaman, and a "helping spirit" in time of need. "Seeing spirits" can be a positive experience for those who find authentication in their role through a privileged relationship with a spirit. In such cases, the seeing of a "personal" or "generalized" spirit can act to validate a position of power.

6. an integral part of one's abilities acquired in childhood. A child's claim to "see spirits" at an early age, a claim that will then generally be asserted throughout life, is respected by other members of the community. It neither indicates sickness nor a mental condition to be present.

7 and 8) those near death, and those who are without the proper balance of issuma, "intellect or other mental activities." For those nearing death or lacking the proper balance of issuma, "intellect," the expected response to "seeing spirits" would be that the person learn to live with the condition in such a way as to minimize interference caused by their experience for those about them.

Many of these agents have nothing to do with either physical or mental disfunction but are due to the unsolicited activities of a "restless" or "helping" spirit. It was precisely this wide range of discriminant attributes that enabled Inuit to link sickness to their total cultural-environmental milieu. Further, the extensive use of such attributes gives the community leverage to regulate sick persons in socially approved ways. The most unequivocable proof of the society's use of discriminant attributes to regulate a society is found in the category of *Kauiŋnininit issumuk*, "mental conditions," where behaviour may be diagnosed as an "unusual experience" or a "mental experience" (see pages 209 thru 214 in Chapter Five) depending upon whether the behaviour is supportive of or in conflict with community codes of behaviour.

A fifth characteristic of the Inuit system was the use of the concept of *inua*, "vital force," which acted to obfuscate the inclusion of illness conditions into one or another category. Inuit see each human soul to embody *inua*, the "vital force" emanating from the deity, and therefore to be sacred. It is this element of the soul that functions in the human throughout life to *repair*, *heal*, and *maintain balance* of the total human organism. The idiom *Immenik atkrilaaqtuq*, "it takes care of itself" -- meaning that one's *inua* was sufficient to correct the condition -- was frequently heard when some minor physical or mental condition was brought to the attention of an informant. *Niaqunguk*, "headache" and *Nuvak*, "common cold" were two such impairments considered unworthy of reporting as sickness.

The foregoing distinctive attributes of the Inuit system for categorizing illness is not exhaustive, but does represent the most significant features of the Inuit system of classification. Hence, its open-endedness, multiple causation (including both cultural and non-cultural pathogenesis), functionalism, use of phenomena extraneous to the domain of illness (from the perspective of western medicine), and the concept of inua, the vital force within each individual, are integral to the perceptual premises upon which attitudes and actions are formulated for Inuit and Inuit-Settler members of the collectivity as well as their respective constituencies.

B. General Differences Examined

White/Settler perception of illness was not identical although sufficient similarity existed to allow them to be classified, albeit loosely, together; neither resembled that of the Inuit or Inuit-Settler population.

Since cognitive diversity between Inuit/Inuit-Settler and White/Settler members of the collectivity, and those social groups represented by them, has importance for the total thrust of the thesis, consideration will be given on the following pages to the more general differences associated by each group with the domain of illness.

1. Different terms were used by Inuit-Settler/Inuit to describe illness than those employed by the White/Settler population. In most instances Inuktitut terms were inserted in dialogue where an Inuit-Settler/Inuit was otherwise speaking English. When the necessity to speak in English was not requisite, then illness terms were almost entirely Inuktitut (see Appendix II).

2. A difference existed between Inuit-Settler/Inuit and White/Settler social groups in their choice of first diagnostician -- the individual to whom they first related their symptoms upon experiencing illness -- in most instances. Exceptions would include physical

traumas of major proportions, e.g., broken limbs, severe gunshot wounds, etc. Normally, however, when an Inuit-Settler/Inuit realized he was ill, he called upon the akiterijuq to discuss his symptoms.

It should be stressed that unlike western doctors in general, the akiterijuq also functioned in the capacity of wife, mother, housekeeper, part-time janitress for the DNLA store, officiated at almost all community functions of a traditional nature, undertook certain subsistence activities in addition to serving the health needs of approximately 550 Inuit-Settler/Inuit individuals. The point I wish to make is that diagnosis did not always take place in a formal setting, i.e., the patient coming to her home. Diagnosis could be undertaken on an outer island while the akiterijuq picked berries with a group of women, while standing in line in the government store check-out line, by means of a telephone call, and so on.

Depending upon the akiterijuq's assessment of the patient's condition she could:

a) dismiss the patient with a joke along with the proclamation that the individual was perfectly healthy,

b) give instructions to use one of the commonly known home remedies,

c) purposely prolong diagnosis until she could acquire additional information from others about the patient's non-medical activities through her private grapevine,

d) arrange an "accidental" encounter with the IGA Nurse for the purpose of confirming some doubt about her tentative diagnosis,

e) assume treatment herself which, if seen to be attributed to a cultural causative agent, could include working with others in the village besides the patient,

f) instruct the patient to go to the nursing station if the condition was one she felt should receive treatment she was not equipped to undertake,

g) or simply telephone the IGA Nurse and tell her the patient should be taken to the nursing station.

All these things she regularly did. Most of the illness in this segment of the community was effectively handled in these ways.

3. The forms of preventive medicine practiced were different for the Inuit-Settler/Inuit population than for White/Settler individuals. Preventive medicine is discussed in greater detail in Chapter Three in relation to the Inuit concept of a healthy individual. For example, the same dietary items that are used to restore an ailing person to health are also used as preventive medicine. The same claim can be made with respect to exercise and adaptation to the environment. Preventive medicine amongst Inuit-Settler/Inuit may be summarily described as follows:

a) dietary,

b) attitudes about physical fitness,

c) distinctive concepts about the type and manner in which one should clothe oneself,

d) attitudes toward contact with a deceased person,

e) the knowledge and use of amulets, and

f) the interpretation of "signs," e.g., the sighting of birds in specific numerical combinations, the sighting of an animal of unusual coloration, changes in the weather -- particularly the wind -- and so on, as a signal to alter some feature of their activities so as to maintain good health.

4. Inuit-Settler/Inuit confined specific areas of illness for diagnosis and treatment entirely to the akiterijuq:

a) when advice was required in determining the precise home remedy to use, only the akiterijuq was consulted,

b) all conditions experienced by males that required treatment for sprains, pulled tendons or muscles, and dislocation of joints (usually acquired through subsistence activities) were treated by the akiterijuq.

c) "Feeling" out the location of an evil or malevolent spirit which has been diagnosed by her as the cause for illness. Associated with this function would be the correct treatment to rid the patient of the spirit.

d) Lastly, all "mental conditions" were treated by the akiterijuq. Only when treatment failed would the patient be taken to the IGA Nursing Station with the request that he be sent south to a hospital (see Bertha, pages 204-205).

Note: All functions assumed by the curer under a) and b) were common features of her practice. An aspect that is hidden by the surface description of her treatment of dislocation of joints, is that the loci of one's inua, "vital force" resides in the joints, hence this function is sacred (see pages 229-230).

5. A marked delay in the time that elapsed between the onset of illness and enlistment of medical assistance from western medical facilities by Inuit-Settler/Inuit contrasted to that of the White/Settler population. Reasons for this delay were due to the following

attitudes and practices among the Inuit-Settler/Inuit population:

a) The concept of inua, "vital force" results in the patient's allowing time for this process to take place (see pages 229-230 for a fuller definition of inua, "vital force"). There is full awareness that in many instances this may not be sufficient.

b) Depending upon the nature of the illness (as interpreted by the patient or his family) home remedies may be tried next.

c) Barring dramatic changes in symptoms that would force the patient to go directly to the IGA station, the normal next step is to go to the akiterijuq for diagnosis. This can involve considerable time in some cases (see pages 21 and 22).

d) If the akiterijuq decides the condition would best benefit from western medical techniques and facilities, then the patient is referred to the nursing station.

e) Although the akiterijuq goes to great lengths to ensure that patients follow her instructions to go to the IGA station, some patients, especially males, will minimize their condition at this point and postpone their visit to the station.

f) When an illness finally reaches the state which cannot be ignored by the patient and previous steps have failed to correct the condition, patients go to the nursing station.

6. There is a reluctance on the part of Inuit-Settler/Inuit to be treated in hospitals in the south of Labrador and other parts of Canada in contrast to other population segments in Nain. Unlike both Whites and Settlers in the community who look forward to their yearly check-ups and do not hesitate to be flown to a southern hospital if the slightest indication of poor health is present, the native population dreads the prospect of being sent to a hospital. Reasons for the Inuit-Settler/Inuit attitude toward hospitals are many, but the most

common complaints I heard were the following:

a) First and foremost is the notion that the healing process is best achieved in the midst of friends and relatives who demonstrate affection and create an atmosphere of gaity when in the presence of the sick. This is not possible when removed from Nain.

b) The small gifts of special health-restoring foods are looked forward to; they are, in fact, seen as a necessity whether they come from friends or from one's family. These foods are not available when one is confined to a hospital.

c) Although rarely do individuals claim explicitly that they recovered from illness due to the intervention of a "helping" spirit, the fact that the possibility of their being helped in this manner is important to the patient. Such spirits are not seen to be present in western medical facilities or hospitals.

d) There is a dread of either parent being removed from Nain for any length of time. The division of labor between the sexes in Nain is one of necessity for survival. If the mother is removed to a southern hospital friends or relatives will care for the children for a brief time, but the heavy workload of women in Nain makes this accommodation difficult.

When a man is sent to a southern hospital it is an even more serious matter. Woodgetting, hunting, and other arduous tasks performed by males are all but impossible for women; those with children find it actually impossible. Other males in the community will try to assist a fatherless family, but the doubling up of workloads of the kind carried out by Inuit-Settler/Inuit males is beyond the ability of most except for very brief periods of time. There are too many families in this situation in Nain for short-range measures to work.

7. Hospital techniques impede recovery in many Inuit-Settler/ Inuit because they frighten, humiliate, or anger the patient. Some examples for these reactions to hospital routine and techniques are:

a) Inordinate attention to the patient's total bodily cleanliness and the requirement that patients wear regulation clothing while hospitalized, e.g., pajamas and nightshirts. The former is viewed as humiliating and the latter an invasion upon the patient's right to wear his own clothing.

b) Partial isolation, and in some instances total isolation from others, and the enforcement of quiet is both frightening and contrary to the patient's concepts with regard to human companionship when experiencing illness.

c) The use of unfamiliar equipment, instruments, and procedures upon the patient, usually performed with little or no explanation, is a source of fear and anger for the hospitalized Inuit-Settler/Inuit.

d) Perhaps the most serious aspect of hospital procedure is the making of unilateral decisions by the professional staff on behalf of the patient, the use of unfamiliar terminology, and the assumption by the staff that a signature constitutes permission for treatment or surgical procedures.

Since multiple norms operated to define the healthy and the unhealthy person in Nain as well as the appropriate action to be taken when illness did arise, members of the collectivity vied for the course that would be followed by the community in keeping with those ideas held to be proper by each representative's social group, or portion thereof. Accordingly, deviation from the norm was not a simple matter to define and corrective action to be taken in each instance could become a protracted undertaking.

C. Discussion of Cognitive Diversity

Within a community comprised of four social sectors who do not share the same cognitive maps to any great extent, how then is meaning arrived at? It is the ground plan rather than shared "psychological realities" that make social interaction possible (a ground plan is a processual model whereby the organism acts, tests the results, then acts again, until the desired goal is reached, and then stops (Miller, Galanter, Pribram 1972: 60-61). The particulars of ground plans are forever changing for individuals in the reality of living, of course. In Nain members of the collectivity, in particular, continually negotiate meaning with other members through acting, testing the results of their act(s), acting again, until they have achieved their goal, or, failed in their objective. This concept of sharing rules for the conduct and interpretation of speech and for achieving a desired goal is not based on the old anthropological notion that all culture forms are shared by all members of a society. Meaning in culture is negotiated by actions; shared values are not functionally necessary for the occurrence of stable social interaction (Mulkay 1971: 185).

Groups, as well as individuals, integrate their behaviour into predictable systems by means of "equivalence structures" (Wallace 1970: 34-35), without extensive cognitive sharing. Knowledge of all subsystems, i.e., domains, within a society are not uniformly shared by all members. One example would be the professional and his audience; the shaman and the patient relationship demands mutual understanding, but it does not demand full sharing of the knowledge that comprises that particular subsystem. The cognitive map of the akiterijuq was certainly not the same as that of the "Former" Chief Elder -- in spite of his belonging to the same social group as the healer -- with regard to health and illness. Both were Inuit-Settlers of exceptional abilities, but the native healer's understanding of the illness domain was highly sophisticated and showed maximum elaboration, while the "Former" Chief Elder's, although superior to the average Inuit-Settler in more traditional cognitive domains, was less detailed and less complete in the perception of principles involved in dealing with illness. What they shared was the abstract knowledge underlying the procedures used to make judgements in the domain of illness. They, and the Inuit-Settler/Inuit community at large, shared the same fundamental premises upon which diagnosis and treatment were based. Whites, on the other hand, did not share even the fundamental premises upon which the Inuit-Settler/Inuit community made judgements about health.

In way of summarizing the ways in which cognitive diversity was managed among members of the collectivity with respect to health and illness, I found the following basic principles to operate:

1. Under certain circumstances one or more members of the collectivity cooperated across boundaries to achieve a solution, e.g., the oil shortage.
2. Interaction did not always follow along lines deemed desirable by one or another arbitrator. That is, no single social group consistently managed to negotiate matters to their benefit, e.g., hepatitis epidemic.
3. Nor were cooperative endeavors between two or more arbitors the only alternatives, e.g., when the "Former" Head of the Community Council could not persuade either the IGA Nurse or the DNLA Manager to arrange for him to be flown to a southern hospital for a severe attack of eczema, he arranged for his own air transportation by negotiating directly with the mission plane pilot.

4. Innovative solutions to health problems were arrived at, e.g., it was announced to the community that the IGA head nurse had retired (two young nurses were brought in to take over the duties of the nursing station). In fact, she had been assigned the duty of "visiting nurse" to the community. None of the Inuit-Settler/Inuit understood she still functioned in her professional capacity, but complained that the head nurse constantly bothered them by visiting them all the time, and wished she could find something else to do now that she no longer had a job.

5. At times compromise between all arbitors was achieved, e.g., the dates upon which holidays and celebrations would take place, or, in the case of Juliana (see Chapter Five).

6. A shifting alliance within the "negotiating collectivity" could be observed depending upon the specific issue under negotiation. It should be clearly understood that although members of the collectivity can be divided into four different social sets, this does not imply that negotiation occurs only between social groups. There are divisions of interests and objectives within all social groups in Nain. When these objectives are the same for specific key members of say, the White and Inuit-Settler social group, then with respect to that issue only there will be an alliance formed. Those forming the alliance will work to achieve their goal against other Whites or Inuit-Settlers not sharing their objectives. Once their goal has been attained, the alliance dissolves. Note the different alliances formed in the instance of the oil shortage in contrast to that of venereal disease in Chapter Five.

7. A "breach," i.e., an act in violation of the rules (see pages 11 and 12), could stop further negotiation from proceeding.

In a general sense I frequently found Garfinkel's explanation of how understanding is achieved between people to be helpful when describing members' activities:

> "Common understanding is never simply recognition of shared contents or rules, but it is always open-ended, brought about in any given case because participants bring it about as their 'artful' (if unconscious) accomplishment" (Garfinkel 1972: 304).

'Artful' was, at times, the only means to describe the creative processes whereby members of the collectivity resolved difficulties arising out of the perceptual differences that distinguished Nain's various social sectors.

There was, however, additional evidence to indicate yet another dimension operated to explain how common understanding might be arrived at between members of the collectivity in certain instances.

The first occasion by which I was alerted to the possibility of a common understanding between groups that was more extensive than I had previously thought came (as all subsequent examples, in an unplanned and spontaneous setting) from an Inuit man with whom I was visiting. In the course of our conversation I commented upon the recent accident experienced by a Settler woman, and remarked that it was undoubtedly due to insufficient knowledge on her part of how to walk upon the icy pathways about Nain. At that, the man broke into laughter; when he had contained his mirth, he asked me did I really think that woman was less able to go about on ice than an Inuit? I replied that according to information obtained from her during a formal interview I had every reason to believe so. "That woman," he said, "could be dropped from an aeroplane, blindfolded, twenty miles from Nain in any direction, and could find her way back home with no trouble at all." She had, it seemed, minimized her competence with respect to her adaptation to the environment in which she lived during her interview with me. By so doing she distinguished herself from the Inuit-Settler/Inuit population who, as acknowledged by White and Settler alike, have knowledge superior to their own with respect to the land.

On another occasion I was speaking with a White man who, in previous conversations, had taken pains to establish that his knowledge of Inuit ways were, after years of association, still superficial. Again, during an informal discussion one evening, I alluded to the tragedy of a particular Inuit man who was a semi-recluse in the village because, as I had been informed by his son, he was ashamed of a facial disfigurement incurred from a severe burn. Upon hearing this, the man exclaimed "Severe burn my foot! That stupid fool was mangled by a seal he thought was dead. You see, one way of keeping a seal from sinking after he's been shot -- if you're quick enough -- is to hold on to its flipper with your teeth while you get a line through 'em to pull him out of the water. Well, this nitwit didn't make sure the seal was dead before he grabbed a mouthful of flipper. Before he knew what was happening the seal swung about and nearly took his whole damned face off." Here again, a White, ostensibly lacking in anything but rudimentary knowledge of the Inuit way-of-life, revealed detailed knowledge of activities associated with traditional subsistence techniques carried out by the Inuit-Settler and Inuit.

A substantial number of such anecdotes were related to me throughout the period of fieldwork. I could only conclude that knowledge supposedly restricted to specific social groups was more widespread between groups than I had supposed. Such evidence was, unfortunately, limited to "communicative competence" (Hymes 1972: vii), and could not be proved by the means of non-verbal correlates. Tentative though such findings are, I feel that common knowledge between social groups in Nain exists in some areas to a greater extent than revealed by more formal research procedures. I confirmed that such knowledge was not withheld from me as an outsider, while shared between social groups within the community, but rather a phenomenon assigned a place of 'oblivion' in the unconscious of persons, coming to the fore when people were offguard and censoring of their verbal output minimal. It is my belief that this dimension facilitates negotiation between the collectivity's members in specific areas while not allowing access to the abstract knowledge underlying procedures used to make judgements by each social group.

I offer the foregoing information with the emphatic qualification that cognitive diversity assuredly exists in Nain in the domain of illness as well as other significant domains. At the same time I suggest that a relationship might exist between negotiating members' 'artful' accomplishments due, in part, to a common understanding originating in the unconscious of its members.

Further research along these lines would be profitable, for it would demonstrate in which areas the citizens of Nain (and elsewhere) share experience and knowledge at a level of which they are unaware, but nevertheless diminishes the barriers that act to separate them.

Nonetheless, illness as a domain is of consequence to the actors of this community and there are differences in behaviour and orientation toward it. Consequently, the research upon which this dissertation is written is seen to be a domain which has legitimate claim for demonstrating general processes. In this instance the choice of illness and health does indeed elucidate the ways in which people in the community of Nain go about doing "social work" on both a specific and general level.

IV. SUMMARY

As members of the community forsake a more traditional identity in relation to medicine for one which uses western medicine as its model, cultural definitions of symptoms and etiology come to more nearly resemble those adhered to by EuroCanadian culture. This is not a tidy process; some concepts of western medicine are integrated into an individual's understanding of health and illness while others are accepted only partially, still others are never accepted.

Demographic changes, artificial increase of the population, new disease pathogens, increased dissonance between the dominant and subject cultures' medical systems, poor government planning, and most importantly, the fact that conditions of illness and disease are so common that they have come to be looked upon as normal, and treated with indifference, means that effective health care in Nain is frequently not possible.

Any of the foregoing circumstances place the burden on the Inuit-Settler and Inuit social subset, and it is in those areas which the Inuit-Settler/Inuit see as crucial to cultural identity where one finds the kinds of difficulties that lead to conflict. Chapter Five will deal exhaustively with the nature of these difficulties. For now, it is sufficient to say that the process of retrenchment has resulted in a state of near-breakdown for the entire community structure. Members of the collectivity do not have the resources available to them to cope adequately with extensive and complex problems that arise from within the village or those imposed upon the village from the outside. The core of the thesis will deal with situations where those individuals who dealt with instances of illness or other community problems, i.e., the "negotiating collectivity," were strained to its capacity and considerable "social work" was necessary to arrive at even a partially satisfactory solution.

Reasons for members' lack of access to resources are numerous: among them, geographic isolation, limited transportation predicated on both weather conditions and available transportation facilities, the economic importance of Nain as a community to the Newfoundland government and the consequent manpower and expenditures allocated to Nain, and ownership of the land by the Moravian Mission (refer to page 221 for further elaboration with respect to land ownership by the Moravians).

What members of the collectivity manage to do in most instances amounts to a "holding" process, within which a great deal of flux occurs, but nothing is allowed to find its way past the "holding" process creating structural change. It works to the extent that members of the collectivity are at times able to seek acceptable solutions to health problems. This is vital, since inability to act and the consequent feeling of helplessness would result in open conflict, e.g., see oil shortage.

One striking example of a case where limits were set that precluded negotiation and resulted in violence was described to me by the DNLA Store Manager. In the early period of his management of the store, those responsible for ordering supplies for the village for the upcoming year and who had functioned in his position before him, had mistakenly estimated the amount of flour required to take the village through the winter. Shortly after he took over the job of managing the store, it was found that there was barely sufficient flour to last through the month, let alone the several remaining months of winter.

When the native population were told they would have no more flour for the year, a mob of Inuit-Settler/Inuit men broke into the government store by force one night and began looting and destroying the store. When the manager was alerted to the situation he saw no alternative but to take his rifle and go into the store, shooting over the heads of the men and informing them in no uncertain terms he would kill any man who did not cease the destruction and looting at once. His method worked, but he knew then that it was not going to be long before another such episode would occur. He then exerted pressure on government authorities to go to the considerable expense of flying in sufficient flour to last the village for the winter.

The dynamics arising from failure of one social group to understand and respond to the needs of another social group can and do result in conflict. The origin of such conflict is not easily discovered in Nain since the interrelationships existing between groups, as indicated, are complex, because of intermarriage between all groups except the Whites, conflict is more often manifested along channels, i.e., individuals, operating between groups, than expressed in open hostility.

The Inuit, throughout the period of contact with western culture, have simultaneously responded to change that was inescapable (or deemed acceptable to them) and borne the burden of maintenance of ethnic identity. For example, Inuit had to learn English in order to participate in the economic system introduced by the Moravians. They also had to accept western medicine to some extent to deal with new forms of illness introduced at contact. The Inuit have continually been forced to reassess their own roles in the traditional social system in order to maintain cohesion in the face of the continual efforts of EuroCanadians to change the traditional social organization. In a similar manner the "negotiating collectivity" has arisen in this community with four clear-cut sectors: it must be a question for further research whether or not it exist in other and different kinds of communities.

One of the objectives of this thesis will be to discover through the isolation of specific episodes in which health matters were negotiated by Inuit-Settlers and Inuit, the nature of this traditional resistance strategy -- that is to some degree a conscious process -- as it effects the illness domain.

In concluding this chapter, I wish to set forth particular observations with respect to cognitive and interactional theory as their relationships have emerged in the working through of this study. There is, in my view, no real conflict between cognitive and interactional theorists since one can, without refutation of one or the other, accept that people have both private and shared meaning(s). While under this shared and private meaning, there may be still a deeper level that operates (the perspective taken by ethnomethodologists) where shared rules to which people do not have conscious access reside. If so, there is a need to develop a means to get at this particular level of meaning. Doing so would not negate the need to study those levels that are of interest to cognitive and interactional theorists.

Having approached this study from member perspective does not imply that I reject the possibility that in doing such analyses of different groups' meaning and actions some universal responses with culturally-diverse forms of expression may emerge. The micro unit of analysis (the small group) is the level at which social scientists must operate at present; this does not mean that by coming to discover what these micro units of behaviour and meaning are, it will not one day lead to comprehending the macro levels of analyses that undoubtedly operate as well.

V. ORGANIZATION OF THE THESIS

First, the distinctive features of the native domain of health and illness were set out. I then reviewed componential analysis and its limitations as a methodological strategy which necessitated a methodology that was more interactional in its orientation. I described the social groups of Nain and presented the key persons comprising the "negotiating collectivity," an informal body of important people who, in fact, prescribe responses to illness. And finally, I examine cognitive diversity at both a specific and general level as it bears upon the effectiveness of the collectivity.

Chapter Two will deal with the fieldwork situation and methods of explicating the health domain and its place in the life of the community.

Chapter Three deals with those norms that Inuit-Settler/Inuit associate with the "healthy individual" and the "unhealthy individual." Additionally, statistics obtained from the nursing station that indicate pandemic levels of disease and accident which prevail in Nain are included in this chapter.

Chapter Four delineates the events that form the ethnographic baseline from which health care and its handling may be viewed, as well as showing how a "negotiating collectivity" emerged in this particular village.

Chapter Five comprises a selection of case studies illustrating illness on three levels: 1) community health, 2) individual episodes of physical illness, and 3) cases of mental illness. These examples illustrate the fact that the collectivity has been pushed to its capacity.

Chapter Six deals with the inherent differences of an ideological and historical nature existing between the two major cultural groups in Nain. Additionally, it looks at the effects of "social work" by members of the "negotiating collectivity" upon the community.

Chapter Seven summarizes the conclusions of the study and closes with a discussion of factors that could conceivably alter the present orientation of the "negotiating collectivity."

CONDITIONS OF FIELDWORK

CHAPTER TWO

I. INTRODUCTION

This chapter will describe my field activities so that the relationships existing betweeen my involvement in the round-of-life that is peculiar to Nain and the kinds of material I was able to bring back will be demonstrated. Too often it is assumed that, armed with sufficient investigative techniques and letters of introduction, the desired data is naturally forthcoming. Every decision, each social contact made while in the field, and of course, the individual personality of the researcher, cannot help but influence the quality and kinds of information that researchers will retrieve. Also, it is easy to overlook the information one doesn't come back with. So, along with accounting for fieldwork methods that brought results, I will attempt to indicate certain aspects of Inuit life that remained impervious to my attempts to understand.

II. ENTRY INTO THE FIELD

I entered the field in August of 1971, having selected Nain as the site for study on the basis of its being the most northerly situated Inuit community in Labrador and the fact that the population is essentially bilingual. Whites, with the exception of the Moravian Missionaries and the IGA Nurse, spoke only English. Settlers used English as their first language, but were usually proficient in Inuktitut -- a fact established through Inuit-Settler/Inuit informants' opinion of the

Settlers' ability to communicate effectively in Inuktitut. Full bilingualism existed for Inuit-Settlers; Inuktitut was their first language, but all spoke English as well. Among Inuit, Inuktitut was also the first language; many spoke English, but not all, especially older people.

Because I had arrived near the end of the short summer months, I brought camping equipment so that I might live independently during the initial weeks of my stay. In that way my entry into the community could be made more gradual, and at the same time give me the opportunity to decide with whom I should live during the remainder of the fieldwork period. There are no accommodations in Nain for outsiders; one makes arrangements with an individual home owner for living quarters.

During the next few weeks I managed to meet all those I knew by now to be "important" in the community, except one; those individuals are listed as members of the "negotiating collectivity" on page 8 of Chapter One.

It was through my own illness that I finally met and became a member of the akiterijuq's household. Although living in the tent had afforded the advantages to which I have referred, it also exposed me to prolific numbers of black flies that inhabit Nain during the summer months. After approximately three weeks in my tent, I went to the akiterijuq's house where I had already decided that I would attempt to find lodging for the winter months. I believed that this plan had little chance of succeeding since two Norwegian anthropologists I had met told me they had been unable to obtain an interview with her during their two-year stay in the village.

When I knocked at the curer's door a woman in her middle years came to the door. She listened as I asked could I rent a room from her, beginning today. She said she was not "Ikie," but to "come in, please." In the kitchen a much older woman, whom I then realized was the curer, was washing on a scrubboard stuck down into a shining new washing machine. She smiled as I stated my case to her, or rather began to, then interrupted, saying that she understood English poorly and that I should tell the lady who had let me in what it was I wanted. I then turned to the lady and presented my appeal, including my reasons for being in Nain -- to study how Inuit people thought about illness -- and added that winter was coming soon and I could not remain in my tent due to the problems presented by the black flies. I later learned that my complaints about black flies were childish in Inuit terms.

A lengthy discussion in Inuktitut ensued between Ikie and her friend, at the end of which, the woman announced I should move into Ikie's home that day. Trying to conclude the arrangement, I brought up the subject of rent. Ikie stopped me at once, saying she did not want to talk about money; I was a guest in her house.

I discovered that evening, after having moved into the house, that Ikie spoke excellent English. I understood that her earlier failure to do so was her technique for "sizing me up" without my awareness. After dinner that evening, I learned that Ikie also knew how to talk about money. Her soft-sell and reversed bartering easily established the price she deemed proper for the privilege of becoming her guest.

A word should be said about Ikie's previous unavailability to social scientists in general. The issue involves what Bales (1951: 87-

90) calls "targetting." Conversation is a "minimally two-party activity and the problem of coordination in a two-party activity is one of finding another party who is available to collaborate" (Schegloff 1972: 372). I was the first social scientist who had come specifically to study the ways in which Inuit themselves look at illness. Of course, the money I would pay for board and rent would also be a welcome addition to her small income. Moreover, I later learned that, unknown to me and to all else in the village, including the IGA Nurse, Ikie was at that time dying of cancer. She died one year after my departure from the field. I speculate that it was a conscious decision on her part to take me in, and, in that way set down for the "record" the nature of her healing art, since she was fully conscious of the rapidity with which the "old ways" were disappearing from among the Inuit.

I lived in Ikie's home for three and one-half months, a fact which facilitated my own acceptance by members of the Inuit-Settler and Inuit communities as well as my understanding of the native medical system. Later, as the number of my informants increased, I moved into a small fishing shack so that my work could be carried out without disrupting the curer's household. I spent a total of seven months in the field, and Ikie and I remained friends throughout.

III. SOCIAL GROUP AFFILIATION

With the objective of studying the Inuit-Settler/Inuit community's concepts and behaviour bearing on illness, I early made the choice to live among them. Almost all previous studies done in Nain (with the exception of the Norwegian couple) had been carried out from the comfort and perspective that comes from living with the White members of that community. These amenities are not to be dismissed lightly in Nain, for it is only the White members of the community who have bathrooms, adequate heating and fresh food flown in during the winter months.

My choice to live among the Inuit-Settler/Inuit community, and associate almost exclusively with them on a day-to-day basis, had its drawbacks as well as its advantages. Once the White community came to realize that I was living with the curer and participating in the Inuit-Settler/Inuit way of life, there developed a resentment toward me that was unmistakable. Fortunately, the degree of resentment varied among members of the White community.

I cannot say how the resentment, which was most intense on the part of the Moravian Minister, would have worked itself out over time, for he, his wife, and his sister went on a protracted leave in Europe just before Christmas. On our one informal encounter the Moravian Minister made it clear to me that he resented social scientists nosing about his village and that he would not be available to me for interview. The missionary's sister, however, did not refuse my visits and I had access through her to the Moravian perspective toward Nain.

Perhaps the member of the White community who experienced the greatest stress as a result of my research in Nain was the IGA Nurse. She too regretted my choice of social group affiliation. She reluctantly accepted my explanation that I saw this to be the best way to achieve the kind of study I had come to carry out. The nurse, additionally, was in an ambiguous position since the IGA officials in the south of Labrador had expressed their disapproval of my proposed study prior to my going to Nain. I believe that she was under orders to reveal only the most superficial kinds of information to me, and I am certain she attempted to follow such orders. In spite of this she gave of her time and of her knowledge whenever she could do so.

Settlers, with a few exceptions, were more hostile to me than any other social group in the community.

IV. FINDING INFORMANTS

It is often thought profitable for the purpose of conducting ethnographic fieldwork to get, and then train informants in their role. This undoubtedly represents the ideal arrangement in many field situations. However, it was impossible to find informants in Nain who would commit themselves on a long-term basis. The nature of their commitment was marked by a spontaneous acceptance at some point in time after the original request had been made. The longest period of time I could expect from a single person was from one to four days for a few hours daily, with a few notable exceptions, e.g., the *akiterijuq*, the Caretaker of the Dead, and a few others. Informants would then either tire of the activity or decide upon an excursion to the outer islands to fish or pick berries. Although I paid my informants, money was a secondary issue with Nain informants.

This attitude stems from several factors. First, it cannot be emphasized too greatly that the "work" which I was engaged in was not perceived by Inuit-Settler/Inuit as productive labor. Work, for them, included activities like hauling water, washing clothes, cooking or mending for the women, and hunting, fishing, working for the government store or unloading boats for the men. Only when I hauled water or made bread was I seen to be working. Thus their daily commitments in pursuit of their livelihood took priority over "working" with me.

In addition to the low priority my work held in the actual scheme of things in Nain friendship always played a significant role in any agreement to act as an informant. Thus, it was necessary to invest a great deal of time in purely friendly exchange before the question of acting as my informant could be approached. These social obligations still held once the appointed time came to work. The money did not alter the social nature of the relationship.

Moreover, Inuit etiquette forbids direct questioning (Black 1969: 167). When first I began working with informants it was politely pointed out that direct questioning of the kind I was using was seen as rude. I was told that my desire to know was not rude, only the way in which I went about finding out. However, no one offered to tell me the appropriate way to make an inquiry. I quickly discovered that the oblique form of inquiry is standard in Nain. For example, I could not ask "are there any people in Nain who have had heart trouble?" Instead, I would venture "I wonder if there are any people in Nain with heart trouble." This type of query allowed more freedom in the informants' responses. The question might be answered, the query might be ignored altogether, or one might be told "I don't want to answer that" or "You should ask someone else that." Such problems were rarely encountered with Settlers or with Whites who made appointments in advance to meet at a set time. No preliminaries were necessary and work could be begun at once. Settlers, incidentally, refused to be remunerated for their work as informants.

The kind of work I was carrying out was well known to the villagers. It was known that I wanted to know about the Inuit concepts of illness. Knowing this, the Settlers refused to take part in the study per se, thinking that to do so identified them as Inuit-Settler/Inuit.

All informants had difficulty understanding why I was there, and, why other such researchers came to their village. Distrust for most of these investigators was transferred to me until I could convince informants I operated differently. Large numbers of physical and social scientists yearly descend on the village of Nain to carry out assorted research projects. These individuals rarely live with Inuit-Settler or Inuit, but continually ask questions and assume privilege in all interactions with the inhabitants of Nain. These individuals are seen as "spies" or "spoiled children" and are held in low esteem by the Inuit-Settler/Inuit. With each new informant I had to go through a period of testing until they were satisfied I was to be trusted.

A. Collecting a Corpus of Disease/Illness Terms

The methodology used by Frake (1961) and Conklin (1955) to elicit the terminologies of skin disease and color, whereby they had informants label referents in the physical world, could not be used in my case. Unlike their studies, terms of illness do not always find visible representation in the physical world, e.g., niaqunguq, "headache," or nukiquanngituq, "weakness." Additionally, unlike Frake, I did not depend for meaning upon informant definition of terms of illness nor those attributes assigned to such terms by informants, but extended my methodological techniques to recover the abstract knowledge underlying all human behaviour associated with health and illness.

Thus, terms were obtained through a compilation of verbally described illnesses and their constituents. Twelve individuals, all bilinguals, were used to elicit terms of illness, four under the age of twenty-one, four between the age of twenty-one and forty-five, and four between forty-five and sixty-five. These informants produced a corpus of terms known to them, giving both the Inuit and English glosses in each case (see Appendix I).

Variations that were observed in informants' eliciting behaviour were of two kinds, 1) a tendency to generalize among younger informants, and associated with that, 2) the failure of young informants to differentiate various morphemes for a single word, e.g., younger informants gave the term illusik, "deformed," in all the following instances as opposed to the more differentiated terms elicited from adult informants:

English Gloss	Older Informants	Younger Informants
"deformed"	illusiluttaq	illusik
"clubfoot"	ittiga illusillok	illusik
"hunchback"	tunnuanijuq iduillingajuq	illusik

The following distinctions illustrate the second difference between older and younger informants' responses. All are recognized terms for thinness of body among Nain Inuit, but only the adults brought that fact to my attention. Younger informants simply gave the term saaluttuq, "thinness since childhood":

Term	Cause	Comment
saaluttuq	thinness since childhood	The only true state of thinness.
-	thinness from sickness	No term is associated with thinness from sickness.
saaluilisimuk	thinness from age	Literally "one becomes thin with advancing age."
peilinik	thinness from excessive sex.	This is a play on words, meaning "starved"; depending on the context it refers to hunger or thinness from excessive sex.

One hundred and twenty terms on which there was substantial consensus were elicited. I make no claim that this is a closed set. This corpus of terms appeared to form a core repertoire which was familiar to all informants. More esoteric terms were occasionally elicited from the healer, the Caretaker of the Dead, and a few others (see Appendices I and II).

B. Sorting and Assignment of Terms

Following the collection of terms for illness, informants were asked to take the cards upon which the terms had been recorded in Inuktitut and English and put them into stacks that "belonged together." The phrase "belonged together" was used by Nain Inuit-Settler/Inuit frequently to describe related features of anything from an animal's behaviour, e.g., "...the seals belong to the sea" or "...deer belong to the land" to tools "...that jigger belongs to the porch (which contained all the other tools)" and so on. After the sorts had been made, informants were asked to state the criteria by which each term had been included in a particular stack. These criteria were controlled for each informant in that each was asked to state the following kinds of information as it related to each term of illness. Terms for the desired criteria were paraphrased to ensure understanding of the type of information required:

> Pathogenic criteria: includes information regarding the specific agent or mechanism that produced or provoked an illness.
>
> Prodromal criteria: the information which associates an illness with previous conditions or identifies it as a spontaneous incident.
>
> Symptomatic criteria: the attributes of an illness which are experienced by the patient, such as the presence of a rash or loss of appetite.
>
> Etiological criteria: the set of circumstances which lead a particular individual to become ill, e.g., an individual contracts a cold due to having been caught in a downpour while improperly dressed.
>
> Elementary criteria: refers to the types of experiences the patient undergoes while sick, but are not disease names themselves, such as "pain" or "ache."
>
> Complex criteria: diagnostic categories labelled by a disease name. They are made up of combinations of criteria the conjunction of which produces systemic diseases such as pneumonia.

Hymes (1969: 430) and others have stated that it is essential to elicit material from informatns in a systematic manner in order to ensure explicitness and limit the logical number of possible models for a taxonomy. Such precautions are indeed imperative in order to arrive at a workable taxonomy. But, like Asch (1972: 9), I found that to expect meaning or precise replication of informant classification principles through componential analysis, even when employing systematic elicitation techniques, was unsound. The above designated criteria are highly useful, but rather than viewing them as a means of arriving at the attributes which form the design upon which individuals act when faced with the reality of disease and illness (Frake 1961: 124-141), it is a "ground plan" (see pages 26 and 27 in Chapter One) that allows people to integrate their behaviour into functional systems without extensive cognitive sharing.

The hierarchial arrangement for different levels of contrast of disease nomenclature was apparent when various verbal responses to the same disease were given and all accepted as correct. Additional information corroborating the hierarchy of contrasts was found in behaviour, or cultural attitudes toward specific forms of sickness. That is, *nuvak*, "common cold," a term sorted into the category *Jannimmuksaussaq*, "Annoyance Sickness," was entirely ignored in real life and if brought to the Inuit-Settler/Inuit attention would be dismissed with the remark *ingemenik atkrilaaqtuq*, "it is best taken care of by itself alone." On the other hand, *sagvilligiq*, "influenza," a term sorted into *Jannimmuksauluq*, "Warning Sickness," is seen as a "White man's disease" and is immediately reported to the nursing station. Observations of these distinctions in on-going behaviour further confirmed the cognitive distinctions specified in the sorting process.

Informants who helped to develop an orthography have already been discussed (see page 48). Those from whom the corpus of disease terms were elicited were not necessarily the same as those who later helped with the sorting. Perhaps half of the individuals who assisted in developing the orthography also undertook the sorting. Fifteen persons undertook the sorting process and agreement was virtually 100%. There were cases of confusion regarding the preferred category in which to place a term, but these were found to be based not upon ambivalence toward the category, but upon vagueness with respect to the particular disease or illness term under consideration, e.g., an informant had constructed for me the term "hypochrondriasis" at my request on the basis of my definition of "one who thinks he is sick a lot." While setting up eliciting techniques prior to entering the field I had decided to insert certain terms that I thought would not exist among Nain Inuit-Settler/Inuit, hypochrondriasis, leprosy, etc. In this way I thought I would be able to establish whether informants were merely trying to accommodate me by constructing terms based upon cues picked up from me.

The card "hypochrondriasis" confused each informant and in turn they put the card aside, not including it in a category. Finally, one quite articulate, older informant became concerned about the term and initiated a discussion of this condition. After he had fully grasped the meaning of hypochrondriasis, he exclaimed "No Inuit do that! That does not belong to us people at all!" In this way, the informants narrowed down the lengthy list of possible illnesses and traumas to those they had experienced or observed. Additionally, through obtaining the interest of some informants on the correctness of words as they represented _them_ and their community, new words were inserted for which there are no English equivalent, e.g., _puikukinga_, "seal finger," an infection from a hemolytic bacteria and _ausiakugiak_, "pain while thawing."

V. OTHER METHODOLOGICAL TECHNIQUES

A. _Techniques for Identifying Social Group Boundaries_

1. _Historical Research_: I did historical research bearing upon both Labrador and Nain prior to entering the field. In this way the emergence of the four social groups in the community was established.

Similarly, the pattern of economic pursuits associated with each group was determined as it changed through time to become characteristic of particular social subsets within the community.

2. *Kinship Charts*: These were acquired for the major family lineages among Nain inhabitants. Indices used to identify such families were: the males contacted by the White community for the 1971 200th centennial celebration. These were those individuals identified as Inuit-Settler/Inuit holding important roles in the community on page 8. Others were selected on the basis of their being asked to officiate at special holidays, e.g., "Young Men's Day," "Young Women's Day," or "Nuliajuq Night." Finally, I obtained kinship charts from those Inuit-Settlers or Inuit who held year-round jobs in the White-administered institutions in Nain.

Through extensive kinship charts, it became obvious that, although the primary roles in the community were traditionally held by males, it was through female kindred that the males became eligible for roles of importance in the community. Males holding important roles in the Inuit-Settler/Inuit community rarely had familial ties, while the wives of such men were related to each other in all but one instance, the shaman's wife. The shaman had moved to Nain in recent years, bringing with him his wife from Killinek.

Some of the important insights into the curer's means of commanding power in the community came through her kinship chart. It was through the *akiterijuq's* lineage that the females of Nain were related, and in turn, their husbands found themselves in positions of power. Power held by the "Former" Chief Elder was through personal attributes and abilities, since he had come to Nain from another village and had few relatives in the community. Further, his only biological offspring was a female; he had early adopted three males, however, none developed the leadership qualities of their surrogate father; hence, power through lineage affiliation was not open to the "Former" Chief Elder.

3. Residence Patterns: In order to ensure viability of subsets, it was necessary to determine the manner in which residence patterns operated among kin groups and the social subsets of the village. Since no viable town plan existed for Nain, I created one. The existing plan was a Newfoundland conceptualization of what the village would look like when the full allotment of government housing had been constructed in Nain. At the time of fieldwork perhaps one-fourth of those houses had been built; the remainder of the existing houses in Nain did not appear on the Newfoundland town plan.

After my own efforts to effect such a plan, I invited several Inuit-Settler/Inuit at different times to come in and criticize my plan. Their additions and corrections added in numerous pathways used by Settlers, Inuit-Settlers, and Inuit to go about the village. To the uninitiated eye, some of these footpaths were not observable. These amendments to my plan illustrated clearly the network which connected particular families while excluding others. In the end these could be interpreted as additional substantiating evidence for my own observations regarding spatial boundaries and group identity in Nain.

4. Resource Utilization Charts: Charts indicating the areas utilized by each of these social groups for fishing, sealing, and caribou harvesting were worked out with the help of informants.

B. Additional Verbal Eliciting Techniques

1. Taxonomy of Illness: Refer to Appendix II.

2. Informal Dialogue with the akiterijuq: The most vital information about the curer, the medical system generally, and her techniques specifically, were often obtained during those moments when, after the day's work was done, she and I sat sipping tea and smoking, while she reminisced about her life's work. I occasionally attempted to carry out more formal kinds of elicitation with the curer, and at times succeeded. However, in the final analysis, Ikie was always the teacher, and I the student. She transferred to me the information she wanted, and in the manner she wanted.

3. Gossip: A point I would like to emphasize in relation to obtaining information either on the subject of illness generally, or activities of the "negotiating collectivity" specifically, is that in a small village such as Nain, gossip is the major form of entertainment. To know, on a daily basis, the developments in each family quarrel, each sickness, each step to be taken by a community leader on a particular issue, the precise time a boat or plane would be due, and so on, are the life blood of a small, isolated community. In general, gossip in Nain was a dependable source of information, if one allowed for the personal style of narration and the tendency to exaggerate among certain individuals.

The style of gossip had long been perfected so that one did not appear to be "gossiping" when transmitting information from one party to another. It was not a disapproved activity -- everybody did it --

especially members of the "negotiating collectivity." The difference between their manner of gossiping and that of the community at large lay in their ability to refrain from gossip in certain areas, a fact that may be attributed to the chances they faced of losing power if their "hand" was revealed entirely.

Certain people in all social sectors of the village held grudges against particular members of the "negotiating collectivity." It was not difficult to find such persons and, through them, follow the small behaviour of the "negotiating collectivity." Those who held grudges were most willing to keep me informed on the activities of those they so disliked without my having to elicit such information. I attempted to establish the validity of such information by independent means.

Too, it should be remembered that I was closely associated with a few individuals of the "negotiating collectivity" and through them at times had direct access to other members of the "collectivity."

4. Medical/Life Histories: The taking of medical and/or life histories was another means by which verbal correlates of illness as well as the previous activities of members of the community (including the "negotiating collectivity") were identified. These histories were taken from all social subsets in Nain except White EuroCanadians (brief, informal life histories were recorded from casual discussion with the IGA Nurse, the Missionary's sister, and certain administrators). Both forms of inquiry, i.e., medical or life history, were virtually identical, the title merely changed to accommodate the Settler's need for a separate kind of inquiry than they knew was used with the Inuit-Settler/Inuit (see page 47).

C. Recording of Behavioural Units

1. Participant-Observation: (a) My access to each social group was not, as mentioned, equal. People who held administrative or religious positions in the village were reluctant to refuse to interact in their official capacity with an accredited researcher. Consequently, with the exception of the Moravian Minister, formal interaction with such individuals was always possible. I had license to enter their establishments and observe, if not fully, at least in general the interaction that took place in Nain's various White administered establishments. E.g., No Inuit-Settler, Inuit, and not all Settlers were allowed to go beyond the door of the government store that separated the offices of the store from that part where merchandise was sold. The two exceptions among the Inuit-Settler were the head clerk of the store (the akiterijuq's eldest son) and the akiterijuq herself. Her position was not gained because the Manager of the government store saw her as privileged; she had for many years had the job of cleaning the entire store on Sundays when the store was closed. She explained this to me in that "...to be a good healer you have to be able to do any kind of work and even dirty work like cleaning that old store." I accepted her explanation, but I also knew that having held that job over many years had given her almost total access to information of significant importance to the village. It was behind those doors and in the Manager's office that instructions from outside officials and administrators were first received either through the mail or by short-wave radio; it was behind those doors that the White administrators in Nain met to discuss current and future issues bearing on Nain economy and life in general; it was in those offices that court was held when the magistrate from Goose Bay

flew to Nain to hold court, and so on. With difficulty, I also established my right to go beyond those doors within the first week of my stay in Nain. I did not over-abuse the privilege, and it was always resented, but I was never denied entry (except when a "formal" meeting was in progress or when the magistrate was holding court).

(b) Through participating in events such as attending church, attending funerals, visiting the sick, attending village celebrations, village dances, attending formal school functions, talking to coastal boat captains and crewmen about what was coming into Nain and what was going out, and through attending community council meetings, going to the outer islands and parts of the surrounding countryside, I was able to record behaviour in its "setting" as the "situation" or "event" occurred.

(c) While living in the home of the curer it was possible to observe the behaviour of patients and the procedure of the curer in many illness situations, since many treatments were in her home (mostly those dealing with mental conditions). She often went to the patient's home to carry out her healing art and I was not allowed to accompany her on these visits. When possible, I did pay my own sick calls to homes after the curer had departed and in this way sometimes learned about the behaviour surrounding sickness and, indirectly, obtained additional knowledge about the behaviour that accompanied the healer's healing techniques.

Through the various means in which participant-observation was carried out, I was able to learn about behaviour that surrounded illness as well as the manner in which members of the "negotiating collectivity" defined and dealt with illness. All aspects of such activity were recorded, but special attention was given those situations that arose when one or more members of that collectivity (or at times the patient himself) breached, or violated, some expectation of some segment of the "negotiating collectivity," or, of the various village social subsets.

VI. SUMMARY

In this chapter I have tried to demonstrate the kinds of field methods that were used to elicit the native taxonomy of illness, those that were used to record other kinds of verbal data, and especially those used to account adequately for the activities and decisions of the "negotiating collectivity."

Isolation of the "negotiating collectivity" was undoubtedly the key to coming to understand Inuit responses to illness in a more realistic sense than a static classification of illness categories. Such a classification does not, in fact, exist, given the circumstances of long term change to which Labrador Inuit have been subjected. The taxonomy that did emerge is included in Appendix II; it does reflect some sense of a classificatory system of illness, but its main utility is as a source for cross-referencing other material gathered through fieldwork.

In closing this chapter, I wish to return to the point made in the introduction when I referred to that information which is not retrieved by the researcher. From a portion of my journal which was begun while still en route to Nain on the Nonia, I will now attempt to convey something of what it is I failed to bring back.

> "Goose Bay, the most southerly community in Labrador,
> is a dividing point between land and people that are

> Inuit, from that which is not. The Nonia, the coastal boat upon which I travel to Nain, had no Inuit passengers prior to its docking in Goose Bay; afterward, a considerable number returning from visiting in Goose Bay, were passengers aboard the ship. My previous boredom with the ten day journey has been replaced by excitement with the prospect of travelling in the company of the people I have come to learn about.
>
> Matching my own change of mood, land forms along the coast also changed dramatically soon after leaving Goose Bay. I looked out my cabin window as evening closed in, looking at the long expanse of crumpled rock coastline; all sounds, except those caused by the ship's passage through the, by now, slate gray water, had ceased. I had noticed before that the passengers appear to become quiet in that interlude between their afternoon's activities and the call for dinner. Rocks that were, by daylight, covered in lichens that reflected the summer's sun, were now obscured in softness. The hills' ridge etched sharply the line between land and the evening sky. As I watched, an old Inuit man of sturdy proportions came from below deck and walked to the railing. He leaned there, at ease, and gazed out to shore. His serene face, and great walrus mustache, could still be seen in the fading light, and, for a long while I watched from my window, this man, as he stood sentinal to the coming night."

It was perhaps two weeks after arriving in Nain that I learned the old man was the Shaman of Nain. Originally from Killinek, the furtherest point north in Labrador, he had completed his summer's fishing in the waters about his former home, and now traveled the coastal boat up and down the coast. He was returning for the last time before winter set in at Nain. I never knew the Shaman; nor has any other anthropologist. No one ever told me other than the barest details of his life. Months later, as I left the field by plane, and looked down and back upon the coastline along which I had first traveled to Nain, I thought again of the Shaman watching night close upon the country that was his. The land, I knew now, still belonged to those who, like him, had made it theirs, and they, despite my enlarged knowledge and trunk laden with data about their ways of life, in many important ways, still remained unknown to me.

HEALTH IN NAIN

CHAPTER THREE

(Part One: The Healthy Individual)

I. INTRODUCTION

The ethnographic baseline from which I view health and illness in Part One is derived from the Inuit-Settler and/or Inuit perception of attributes associated with these states. Cross-culturally, definitions of health and illness are necessarily related; some are culture-specific, however, while others are shared by all groups. I see it to be necessary to understand a culture's view of traits associated with the healthy individual for only when a people's concept of normal is known can their definition of aberrant behaviour or sickness emerge. I have not elaborated upon EuroCanadian concepts associated with good health since the perspective of EuroCanadians who have had a direct influence upon Nain inhabitants is thoroughly examined in Chapter Six.

II. A DEFINITION OF HEALTH

No broadly accepted cross-cultural definition of health is available, for health is not easily defined by objective means. It has been assumed on a superficial level that health is the absence of disease, but this definition is far from satisfactory. One must move beyond the mere presence or absence of disease in order to fully comprehend the nature of health.

Health has its biological roots to be sure, but biological data have been differently interpreted in both time and space by our own culture and by others. Each people, in each place, in each time, has had its own concept of "health." Thus, the health of a particular group of people must be defined in the particular case. What it is to be well or sick is also governed by the available methods of measurement, clinical and laboratory, as well as the ideas by which a people live (Temkin 1953: 8-23).

To further complicate the matter, ideas of what it is to be well or sick are supplanted by other ideas through time. In western culture some of the explanations for disease have been: the ancient Doctrine of Temperaments based on the humoral concepts of pathology, the explanation of sickness based on Demonology, and the mechanistic concept of psychic determinism of Freud, to name a few. It is possible to find evidence of all of these concepts of disease causation co-existing in present western society. This conceptual multiplicity probably occurs in all societies (although it has not been documented). Moreover, there is a strong bias that impedes an adequate definition of health and disease, that has for centuries perpetuated the notion that folk medicine and so-called medical science are separate domains. I do not accept this position although I fully recognize the differences that motivate each; these differences will be further explored in this and subsequent chapters.

Such processes operate in Nain at present. Specific ideas from western medicine have been, and continue to be, incorporated into the Inuit-Settler and Inuit medical model, i.e., congenital illness concepts and explanations for diseases introduced by contact are taken almost entirely from western medicine. Ideas regulating good physical health increasingly incorporate notions from western medicine. Concepts relating to mental health, however, have not been borrowed from western medicine, for the most part, but are still governed by the older ideas associated with the Inuit belief system.

Resistance to change in the category of "mental conditions" (this is a technical term of the Inuit: *Kauiŋnininit issumuk*), may be attributed to the fact that the most important aspect of medicine is its social meaning (see Chapter Six). It has, because of this social meaning, acquired a function far beyond that of counteracting the disruptive effects of disease. Disease is an important sanction against antisocial behaviour, providing the services that in our society are rendered by courts, policemen, teachers, and soldiers (Ackerknecht 1971: 68). In a society of this kind, the medical practitioner holds the keys to social control, and medical diagnosis can even become a kind of "social justice" (Ackerknecht 1971; Harley 1941; Hallowell 1941). Simply put, the healthy individual in this kind of society will closely resemble the "ideal" individual. Conversely, people exhibiting antisocial behaviour and/or poor physical health, threaten the family and the community.

Because different social segments of the community hold distinctly different ideologies, the "negotiating collectivity" has come into existence in Nain as a reflection of this ideological diversity. Through their continuing efforts to arbitrate the kinds of activities associated with medical diagnosis and treatment these individuals change the definition of health and sickness through time. Despite Inuit-Settler/Inuit efforts to maintain their own concepts of illness in specific areas, e.g., mental health, community negotiation of health matters will, at times, modify these beliefs and change will occur (refer to Chapter Five for evidence).

III. MANIFESTATIONS OF THE MENTALLY HEALTHY INDIVIDUAL

Although physical difficulties might exhibit more striking attributes upon first encountering them -- congenital deformaties or amputations for example -- their handling in fact receives far less consideration by members of the Inuit-Settler/Inuit community of Nain than the treatment of one said to be issumaitsissaq, "mentally ill." So long as physical conditions are maintained at a level that does not interfere with the ability to function, little attention is given it.

Maladaptive behavioural disorders are more serious in that they threaten the social norms and by doing so involve the entire community. Social norms stipulate correct attitudes and behaviour, and define what it is to be mentally healthy. Viewed as such, social norms are simply a less organized form of social control, which is accomplished through diffuse sentiments which have been translated into behaviour by the impromptu social support given them (Hughes 1960: 284-285). This, I think, explains the priority attached to mental health among members of the Inuit-Settler/Inuit population of Nain. It also explains why Inuit-Settler/Inuit members of the "negotiating collectivity" give far more attention to situations which threaten to overturn traditional views of mental health, for it is through these concepts that they are able to maintain identity and insure social order and cohesion along lines they see to be appropriate.

For the Inuit-Settler/Inuit population in Nain, if one's issuma, "thought and other mental activities" function properly then one is seen to be mentally healthy. Issuma has been described by Briggs as:

> "...a broad term referring to abilities that we consider mental or intellectual.....it is the possession of *ihuma* (the same as *issuma* in the Nain dialect) that makes it possible for a person to respond to his surroundings, physical and social, and to conform to social expectations. *Ihuma* is, or should be, a governing force in an adult's life. Children are thought to be born without *ihuma*, and accordingly, as I have said, adults who show little evidence of possessing *ihuma* are spoken of as "childish" (nutaraqpaluktuq).....A person who has (or uses) *ihuma* is cheerful but not giddy. He is patient in the face of difficulties and accepts unpleasant but uncontrollable events with calmness; and he does not sulk (qiquk), scold (huaq), get annoyed (urulu), or attack others physically (ningaq)" (Briggs 1973: 359-360).

Like Briggs, I found that various kinds of identifiable behaviour were subsumed under *issuma*, acting collectively as the ethos from which social control within the society was derived. Even though the Chantrey Inlet Inuit studied by Briggs had been subject to less contact than Nain inhabitants, I found that among Inuit-Settler/Inuit adults concepts relating to *issuma* were in most instances the same as those reported by Briggs.

On the following pages I will discuss in greater detail certain traits I found to be important under the broad concept of *issuma*, for although Briggs discussed some of these qualities, she failed to examine the priority of consistency of behaviour in relation to other traits of emotional expression and/or good mental health. This may be attributed to the fact that Briggs' focus was psychological while mine was social.

A. *MaptoneK tange*, "Consistency"

Inuit gauge the quality of mental health by the consistency of one's actions as well as the kind of behaviour exhibited. Behaviour is measured in accordance with the community's standards of regularly expected responses firstly, and with the pattern that has been habitually associated with the individual, secondly. If an observer has come to be aware of the value of moderation, for example, he will encounter situations in which people are behaving quite immoderately with the approval of others. But this is clarified if the forms of sanctioned deviation are understood, and additionally, that allowable variant behaviour itself must be consistent for those persons acting under permitted forms of deviation.

In Nain, the following mandates were found to operate: an individual must have evidenced a specific form of atypical activity since childhood and demonstrated that peculiarity to be an integral part of his personality. If deviant behaviour of that kind has been accepted by the community it will not, in spite of its being different, be revoked in later life. Another exemption is associated with occupying a role which permits variant behaviour, and the third is associated with atypical behaviour while under the influence of alcohol. The latter exemption is common and has serious implications for the viability of the traditional culture since it threatens not only the standards by which the mental health of an individual may be judged, but the means by which cultural identity is maintained. If individuals deviate from norms commonly followed by the community and can claim exemption through any of the foregoing mandates, such behaviour is allowed.

The following case history illustrates a type of unusual behaviour which was allowed only two women in the community. The only other time similar behaviour was ever observed by me was during the performance of traditional games during celebrations surrounding Young Men's Day and

Young Women's Day. In the following situation, one woman was entitled to atypical behaviour of this kind due to her role as curer, while the other woman was permitted such behaviour due to having been that way "since a child." Additionally, the behaviour was justified in that the specific form it took had been consistently engaged in by the two women for almost half a century.

Case History #1

> When standing in the check-out line at the government store one morning, an old lady walked in the store. The moment she entered she dropped to her hands and knees, began to growl and then rushed across the floor toward the curer who was doing her shopping. The outburst startled me, for I had no indication as to what it meant and knew it to be a departure from anything previously observed.
>
> For a moment I thought I had failed to realize the woman was mentally disturbed in spite of having been around her on several occasions. But, to my amazement the curer dropped to all fours and began moving toward the first woman, also growling like a bear. They proceeded to snap and growl at one another, pawing as though in battle, and in general put on a good show. People in the store were enjoying the little drama and laughing. The man in front of me turned and remarked "they've been that way with each other all their lives." When they had ceased their play, the curer came over to me in the line, still laughing, and said "that old woman and me, we've been playing like that since we were girls."

Those who were allowed unusual behaviour were still bound by internal laws of consistency in relation to their particular pattern. That is, a role of power in the community did not give one the right to behave randomly in the exercise of that power. It allowed only that one could express specific behaviour not allowed others, e.g., (see pages 10 and 11).

Individual emotional patterns of people residing in the village are known to each member of the community and it is departure from one's own pattern that signals a potential problem. One or two departures, if minor, are usually ignored, but if such conduct persisted then it was seen to indicate that the person was in some kind of difficulty. It should be noted that all departures were not automatically interpreted as mental illness. Rather, it could indicate that someone was under a curse, had been visited by an "evil" or "helping spirit," was preparing himself for a new role, had become physically damaged, or, had become mentally ill (see Chapter V, section IV, case B, for an indepth explanation of how these distinctions are made.)

B. Ikubliariktovok, "Moderation"

Moderation in the handling of emotions, material possessions, strength, and abilities constitutes the Inuit ideal. This discussion is restricted to the moderation of emotions. The importance of moderation in psychic reactions to good mental health is, once again, linked to the concept of issuma, "thought or other mental activities." If one concentrates on a single idea too long or reacts excitedly to events in one's routine life, it is a bad sign and can indicate too much issuma, a condition which, if not checked, can lead to mental illness. Anthropologists and other investigators coming to the Arctic often become suspect because they are seen by the Inuit to be preoccupied with a single subject. I frequently encountered difficulties with informants due to my constant interest in the subject of health/illness. It was not too unusual to have an informant suggest that we talk about something else in the middle of a work session. Informants themselves did not tell me this was due to their unease at my appearing to have too much issuma, but my Research Assistant did tell me this was the reason for the informants' behaviour.

If one worries too much about a concrete situation, even where actual danger exists, he is seen to possess too much issuma.

Case History #2

On one occasion the curer with whom I was living went "outside" to the outer islands with friends for a three day trip. She had not returned by the fifth day and I was worried about her failure to do so. I constantly looked out the window toward the bay, watching for her return. Her elderly husband, on the other hand, did not express any concern, did not mention her name, and maintained his cheerful demeanor throughout her absence. On the sixth day I approached him and told him of my concern. He remarked only that the "weather is bad," meaning, of course, she was delayed due to weather conditions. When she returned after being weather-bound for over a week he only casually greeted her.

None of her children had inquired about her during her absence although she was greatly loved by her family. Only I had been immoderately worried. The old husband remarked to his wife at the table on the night of her return "The kallunak, "white woman" didn't think you were coming back," at which they both laughed.

In situations of personal emotional distress, the ideal of moderation also prevails. Because of this it was sometimes difficult to correctly assess the intensity with which emotions were being experienced by Inuit.

Case History #3

A young woman I had been particularly close to came by one day following a serious breakup with her boyfriend. The woman supposedly stopped to warm her hands, but as she was preparing to leave, she said "N" has a new skidoo, but he doesn't have a girlfriend any longer." With this, she stepped quickly through the door. My Inuit Research Assistant, who had been present, explained to me that the woman was "almost out of her head" she was so upset, yet I could detect only mildly disturbed behaviour. She apologized to me when next we met for the way in which she had "blown up" the day she had stopped by my house to warm her hands.

Too little issuma is also seen as a problem, but it is not regarded with fear as is the excess of issuma. Too little issuma is associated with mental retardation (or a general failure to mature emotionally, yet is not retardation per se), chronic sickness, and temporary emotional problems. Two examples of insufficient issuma which are viewed with regret, i.e., there is thought to be no point in trying to modify behaviour of this kind, illustrate the forms such behaviour may take.

> Case History #4
>
> People, as I have said, enter without knocking in Nain. Thus, I was not surprised when a strange boy of about eight walked into my house one afternoon, and began to investigate. As he became more detailed in his search I realized this was not typical behaviour for an Inuit child. Although curious, most Inuit children never touch one's personal articles without permission. I watched without comment until he found my tape recorder and began to punch buttons, at which time I told him to stop. He reacted by increasing his activity, and finally became destructive. When talking failed to stop him, I took him bodily and sat him outside the door. Later inquiry from Inuit friends revealed he was without much issuma, and that he might be retarded. No one was upset about his behaviour, but I was warned to watch him closely when he came to my house.
>
> Case History #5
>
> I noticed a man in his fifties who spent a great deal of time around the government store one day, standing outside the manager's office while the manager and I conducted an interview inside. I mentioned the man's presence to the manager, and stated that I preferred that our conversation not be overheard. He dismissed the man's presence by saying "he's harmless, ignore him." Later, I asked others about the man. Most replied the man didn't have enough issuma for it to matter what he heard. I wanted to know if he was retarded, to which they replied that he was not retarded, but that nothing really mattered to the man.

Thus, too much, or too little of any emotion or mental activity is seen to be undesirable by the Inuit. Only the moderate expression of these qualities are appropriate to the mentally healthy person. What precisely is "too much," or "too little" (cognitive variability, of course would require investigative techniques of a different nature than those used in this study in order to arrive at an exacting measurement of moderation in its use. I can add only that informant evaluation in the assessment of those with either an over-abundance or insufficiency of issuma was remarkably consistent), were not determined absolutely.

C. Inulinek, "Gregariousness"

A healthy person desires the companionship of others. "Loneliness" has a much broader meaning in Inuktitut than it does in English, and can indicate unhappiness because of the absence of others, the feeling of being left behind, or the silence and withdrawal experienced because of such feelings. Generally though, the meaning given by informants is "due to the absence of others" (Briggs 1973: 352).

It is not only important that Inuit themselves have companionship, they are distressed to see others in circumstances they perceive as lonely. In instances of this kind individuals will, at times, persist strongly in their efforts to alleviate one's loneliness. Upon first moving into the home of the curer I was uncommonly cautious to not impose my presence upon others of the household. My behaviour was interpreted by them as loneliness. A few weeks later, apparently upset by my continued failure to socialize sufficiently, the curer's son, probably at the suggestion of Ikie, approached me and stated "You must promise to go be with people more, I don't want to have to keep telling you not to be lonely!" It was in this way that I came to understand how important it was that people were not alone, and began to seek company, as the

Inuit did, for its own sake, and for the sake of staying healthy. Staying healthy, it appeared, was something that one constantly worked at.

Simultaneously I began to make note of the kinds of activities which drew people together, and the frequency of such activities in people's daily lives. In addition to the quasi-formal occasions that brought people into the company of others such as visiting, birthday parties, "New House" parties, i.e., when one was finally allotted one of the new houses being built in Nain, they held a "New House" party on the first day they moved in, drinking parties, dances, movies, church services, political meetings, choir practice and performance, Brass Band practice and performance, Rock Band practice and performance, and work-related activities, there were numerous formal events that served to draw people together throughout the year. These were:

The Xmas Tree Competition
Christmas Celebrations
Nuliajuq Night
Young Men's Day
Young Women's Day
Married Couples' Day
Weddings

Children's Day
Widow's Day
Easter Celebrations that
  included the Easter
  Games, a small version
  of Arctic Olympics.
Funerals

All of the just listed formal events shared features in common. Attributes found to exist in all events were:

1. The putting aside activities considered to be "work,"
2. the gathering of people,
3. a new focus of attention, and
4. the consumption of food and/or drink not normally available.

Characteristic of many, but not all of these events were:

5. dressing in one's best clothes or in costumes,
6. the exchange of presents,
7. competition,

8. excessive emotional display,
9. ridicule of others,
10. display of physical prowess,
11. aggressiveness, and
12. the leaving of Nain proper.

In spite of the frequency of personal interaction in Nain, emotional intensity was generally absent from encounters. Heated dialogue and deep emotional involvement were never observed at such times. Casualness marked the quality of such interaction; even entries and exits to people's houses occurred without ceremony. No one knocked upon entering, no one said "hello" or "goodbye," but came and went when it occurred to them to do so. Such an atmosphere helped to avoid the usual hazards which accompany intense interaction; it also offered a form of self-protection in a community where people desire the company of others, yet must have some means for regulating the extent to which they wish to participate at any one time. Frequent interaction, in other words, allowed on-going social regulation between members of the community of one another, while the casualness of such interaction negated the personal threat that can accompany ritualized, formal social interaction.

IV. DEGREE OF ADHERENCE TO SELECTED TRAITS OF MENTAL HEALTH

The degree of adherence to the foregoing traits have been broken down by social group, age, and sex in Table I, page 76. Cognitive differences are demonstrated for each social group. Partial x's indicate lack of full adherence to a particular trait. Findings for each social cell were arrived at by inference through eliciting the symptomatic criteria associated with poor mental health from informants. In addition, medical/life histories, formal interviews, casual conversation and the observation of routine daily behaviour were used to determine the degree of adherence each trait held for particular segments of Nain's population.

All Inuit-Settler/Inuit informants indicated by verbal statements and behaviour in their daily lives that one who possessed good mental health "acted his usual self." Lack of consistency was remarked upon by Settler women in conversation, although no indication that it was one of their criteria for mental health could be determined. This lack of corroboration is seen to be due to the different motivations that lay behind Settler women's interest in behavioural changes of persons in the village in contrast to the motivations of Inuit-Settler/Inuit. Settler women are more sedentary than their men (and much more sedentary than Inuit-Settler/Inuit women) and have undoubtedly developed the habit of close observation of others for a variety of reasons, among them, a means to pass the time in an isolated village. More importantly, however, is the fact that Settler women did not interpret variations in behaviour to indicate the possibility of a curse, witchcraft, or mental illness.

There was no indication that any social segment in Nain other than Inuit-Settler/Inuit held the trait of moderation as necessary for mental health. Most likely some individual Whites or Settlers perceived moderation as a desirable quality, but the group as an entity did not verbalize or behave in ways that indicated moderation was requisite to mental health. An immoderately fierce tempered Settler or White was seen by other Settlers and Whites as having "strength" or his being "just that

TABLE I: Inuit Traits of Mental Health contrasted by Social Group

A. Gregariousness

SOCIAL GROUP	Under 15		15-30 yrs		30-45 yrs		45 yrs +	
	Male	Fem.	Male	Fem.	Male	Fem.	Male	Fem.
White								
Settler	x		x		x		x	
Inuit-Settler	x	x	x	x	x	x	x	x
Inuit	x	x	x	x	x	x	x	x

B. Moderation

SOCIAL GROUP	Under 15		15-30 yrs		30-45 yrs		45 yrs +	
	Male	Fem.	Male	Fem.	Male	Fem.	Male	Fem.
White								
Settler								
Inuit-Settler	x	x	x	x	x	x	x	x
Inuit	x	x	x	x	x	x	x	x

C. Consistency

SOCIAL GROUP	Under 15		15-30 yrs		30-45 yrs		45 yrs +	
	Male	Fem.	Male	Fem.	Male	Fem.	Male	Fem.
White								
Settler				x		x		x
Inuit-Settler	x	x	x	x	x	x	x	x
Inuit	x	x	x	x	x	x	x	x

way," while Inuit-Settler/Inuit would avoid that individual because they saw him as having no control over himself, or, too much issuma.

Gregariousness, or "wanting to be with others" was found to be unanimous for all age and sex categories of Inuit-Settler/Inuit. The fact that Settler men frequently sought the company of other men accounts for the partial x's shown in Table I. Nonetheless, Settler men did not state in either formal or informal verbal contexts that gregariousness was a trait of good mental health. This again, indicates that the motivation for wanting to be with others among Settler men was different from that of Inuit-Settler/Inuit. It is tentatively suggested that Settler men acted in ways that put them always in the company of other men due to the necessity of their utilizing the same technological base, in most instances, as Inuit-Settler/Inuit males from an early age in order to acquire familiarization with land, animals and technology in that part of the world. That skills of this nature were best learned from Inuit, in most cases, means that peripheral behaviour would be similar for all social groups who use what is essentially an Inuit technological base.

Partial x's shown on Table I for Inuit-Settler and Inuit children under the age of fifteen (15) for the traits of moderation and consistency can be explained in that a great range of accepted behaviour is permitted children. Inuit-Settler/Inuit boys are seen to become men at fifteen in Nain and their behaviour undergoes change from that point on (in a manner that is noticeable) to resemble that of adult males. Girls may take somewhat longer to assume the role of adult women.

V. MANIFESTATIONS OF THE PHYSICALLY HEALTHY INDIVIDUAL

As previously remarked upon, physical health did not appear to have the same capacity as mental conditions to threaten the existing social norms. Poor physical health of a chronic or serious nature was not ignored by the community, but the on-going fluctuations in individual health patterns were not of central importance to the Inuit-Settler/Inuit community. Weather had priority over an individual's influenza as a topic of conversation, for example, or what had recently arrived at the government store, or, even what one was going to have for dinner.

There was a matter-of-factness about physical malfunctions. This was clearly demonstrated to me on one occasion when a man, unknown to me, passed the window in front of which an informant and I sat working. In response to my question about the man's identity, the informant replied "...that's ____________, he's only got one ball and one lung," and without breaking stride, continued to discuss the topic of conversation in which we had been engaged. Another case, less concise, but more informative, involved an Inuit woman with a severe hunchback (kyphosis). She had, in her youth, I was told, been courted by some of the most eligible young men, and had been won by one of Nain's most outstanding hunters. She accompanied him on almost all his hunting and fishing endeavors, for they lived close to the land still. She was seen as a model wife, she had bourne four healthy children, and was asked to officiate as co-hostess to Nain's many celebrations which require not only the best of traditional cooks, but the best of traditional wit and humor. The akiter-ijuq was invariably the main hostess at such affairs, and the two of them were essential to any formal Inuit-Settler/Inuit function. I heard much about the woman's abilities from people in Nain; I did not hear her physical handicap referred to on any occasion.

These two illustrations demonstrate the whole point about physical health from the Inuit-Settler/Inuit point-of-view; if one can function in one's expected role, then finer nuances of the bodily condition are of little interest to people.

Rigid concepts about what was essential to maintain the body in an ideal state would be maladaptive in view of the real flux in the local environment; failure of caribou to migrate at times along predicted routes, the failure of the fisheries, or the failure of birds to migrate at optimal times, as well as harsh and unexpected changes in the weather, have always been variables with which the Inuit have had to deal. Living with uncertainties that effect both food supply and opportunity to go abroad to search for food has perhaps enforced a greater degree of expected variation in standards associated with physical well-being. Additionally, the unusually high rate of accidents and traumas experienced on an on-going basis through Koasimajuq, "frostbite," puikukinga, "seal finger," qukitausimajuq ikkiliq, "gun wound," illuiq, "snow-blindness," and the like, are realistic expectations of those who engage in Arctic subsistence activities. Hence, inconsistent diet, exercise, and minor traumas associated with climate and hunting mishaps are not looked upon as incapacitating or rendering one "unhealthy." Their concept of "healthy" embraces many complaints that in our more moderate climate and regulated economy have come to be called illness or disease, e.g., headaches, backaches, common colds, as well as those listed above that occur in our society: gun wounds, frostbite, or snowblindness. My research assistant had to have a chest x-ray upon coming to live in Edmonton. The doctor found nothing seriously wrong with his respiratory system, but noted that my assistant had several fractured ribs that had healed in a way that put pressure upon his lungs. When asked the nature of the accident in which his ribs had been broken, my assistant could not at first remember. At length he recalled an old injury incurred while on a wooding expedition that had caused him to experience soreness in his ribs for several days, but then, he added "it soon went away."

Consequently, areas in which I was able to observe behaviour undertaken by Inuit-Settler/Inuit to ensure good physical health were limited. Those most easily isolated were diet, exercise, and the adaptation and use of the environment.

A. Diet

What comprised the "correct" diet varied, as one might expect, among each social segment of the village. Amongst the Inuit there was a decided preference for creatures obtained directly from the surrounding environment. Locally obtained food was the only "real food," or "fresh food"; their efforts to secure local food were greater than any group in Nain. Settlers, surprisingly, managed to secure more local food than did the Inuit-Settler. Inuit-Settlers, in spite of their preference for local food, consumed primarily those foods they could puchase at the government store, supplementing this with local food whenever it was possible to do so. This is explained in that Inuit-Settlers were employed in make-work job projects in the village throughout the year whereas Settlers were not. Either a Settler had a year-round job as a bookkeeper in the government store, or perhaps in the power plant, or, he spent his time in the search for animals, both for food and for selling furs or sealskins to the government store for ready cash.

Although Inuit-Settlers utilized the "White Man's" diet more fully, they still had a deep craving for animals of their own country and referred to locally obtained food as "our food." "Fresh meat" meant any traditional Inuit meat, and all meat brought into Nain in its frozen state from outside Labrador was not perceived as fresh. Inuit-Settlers, when unable to secure "fresh meat" for themselves, negotiated on a continual basis with relatives and friends who did pursue traditional hunting activities for fresh meat.

Variety in food was considered an essential to physical health, but variety was perceived differently among Inuit-Settler/Inuit than among White EuroCanadians. Variety, for them, came not from many different forms of food, but from that which is within the animal itself. Variety of this kind was obtained through eating every part of the animal that was not known to be dangerous to man or incapable of digestion. This would include, for example, crumbly bone, cartilege, gristle, marrow, blood, oil, skin and many other animal parts that are normally discarded in North American culture. Variety, both aesthetic and nutritional, was also obtained through a wide range of curing, aging, and cooking techniques.

Sickness, in many instances, was attributed to an insufficient diet by Inuit-Settler/Inuit. At such times special preparations were given the ailing person; a partial list of foods seen to be especially beneficial to restoring health are:

1. Fresh blood at the site of a kill;
2. soup made from blood;
3. broths made from animals, but especially spruce partridge;
4. cod brain alone, or mixed with fish head cartilege and liver of the fish;
5. cod liver "jam" (cod livers that have been cooked slowly for many hours until they reach the consistency of jam; these are often mixed with berries;
6. seal liver;
7. fox thighs, and
8. red and blue berries

Older Inuit-Settler/Inuit see the high consumption of soda pop and candy by younger Inuit-Settler/Inuit as an unhealthy dietary practice. There is, nonetheless, no effort made to prohibit the large intake of such sweets by children since the individual autonomy of children is respected amongst Nain Inuit-Settler/Inuit.

Over-eating was not observed in any instance except on village-wide holidays. On these days eating became a feast in which all participated. There was, I feel, a food anxiety present among the Inuit-Settler/Inuit, but its form of expression was indirect. Instead of mentioning one's hunger, anxiety was expressed through continual discussion of the weather and when one would be able to fish, hunt, go for ducks, and so on. On one occasion when I was weather-bound on an outer island with a large family, and food gave out, I suffered severely from food deprivation. During that time, not even the smallest child begged for food or mentioned their hunger. The anxiety was there, but the manner in which the "proper" Inuit would behave when faced with a shortage of food was one of utmost patience, good humor, and lack of direct reference to the fact that they well might starve.

B. Exercise

Exercise, for the most part, was acquired through the ordinary functions of one's daily routine. Formal approaches to exercise were found only on rare occasions. Such occasions were typically associated with long confinement to one's house due to bad weather conditions, in the training of young children, in children's play, and sometimes in the context of entertainment in the evening amongst friends and family. These exercises rarely resembled those we associate with "gym classes," but appeared to be for purposes of limbering the arms and legs, strengthening the back, restoring circulation, and developing physical endurance generally. In fact, exercises were marked by both spontaneous and individual choice. It was not uncommon to see someone engage for a period in a leg exercise that required one to hold first one leg straight out and at an angle to the body, then give the leg several very hard jerks, then repeat the procedure with the other leg. Swinging the arms around several times in a counterclockwise motion was another typically observed exercise. Following these, the individual might suddenly turn to working string tricks, or engage in a game of cards (this sequence particularly applies to people who are confined to the house because of inclement weather).

Sitting with the legs straight out in front of the person seemed to be a preferred way of sitting under certain circumstances; especially when long, painstaking jobs were being executed. The curer, at sixty-five years of age, did her sewing from atop her kitchen table. Here she sat as described, with her legs together and straight out in front of her, while her back was held without support of any kind, completely straight. She would sit for two to four hours like this sewing.

Where one could find references to healthy foods, rarely did I hear anything said about the kinds of exercise required for a healthy body. I could only observe behaviour associated with exercise.

C. Physical Health vis-a-vis the Environment

All children, male and female, are early exposed to the cold. These are short exposure periods. Typically, a child of an Inuit-Settler or Inuit family will be allowed to run about in the first hours of the morning barebottomed with only an undershirt on, until they have had their first bowel movement of the day. They are then dressed. Most families cannot afford to keep the stove burning through the night and allow children to play in this undressed state at temperatures ranging from -30°F. to 0°F. until the house has become warmed by the day's first fire. In addition to the scarcity of fuel that contributes to this situation, the Inuit-Settler/Inuit think exposure to the cold makes the child stronger.

Children are not encouraged to play inside the house. Except for the hours actually spent in school, all their time is spent playing outdoors. Some of these games are quite dangerous, from our perspective, but are encouraged, even expected, in order that children may grow up to cope adequately with the environment. Boys, for instance, engage in a game that requires them to jump from ice-pan to ice-pan. This teaches the child many things about the nature of ice, and the body's ability to negotiate upon exceedingly thin ice momentarily as they make their way to more stable ice without drowning; Inuit normally do not learn to swim, yet adults refuse to intervene when their own child first begins to participate in this game.

Another observation relating to the correct response to cold was that one never came in from the outdoors and approached the source of heat. Instead, even when actually frozen in some part of the body, one would enter the house and go to the furthest point in the room away from the stove. There they would sit while experiencing ausikuugiak, "pain while thawing." Only when their body temperature had become normal would they move closer to the source of heat. One who "hangs about the stove" is said to be "puny" and "would never make a strong Inuit."

No degree of adherence to traits associated with good physical health could be determined for the different social groups in Nain. This was not only because of insufficient verbal evidence, but also due to the fact that the demands of the northern Labrador environment have been modulated for all Whites and some Settler through the means of technology not available to the Inuit-Settler/Inuit, i.e., better insulated homes, adequate heating, inside water supply, inside toilets, superior clothing, and so on.

(Part Two: The Unhealthy Individual)

VI. INTRODUCTION

Part Two of this chapter looks at disease and trauma as they are accounted for statistically by the IGA nursing staff in Nain. In addition, specific illness categories will include a brief account of how, in contrast, the Inuit-Settler and Inuit view that condition. So that the rates and kinds of illness experienced in Nain can be compared to Inuit peoples living in o her parts of Canada, I have selected two studies for purposes of contrast. First, however, I would like to say a few words about the lack of uniformity between categories used and statistical criteria upon which each study is based, so that my own analysis and comparisons may be properly interpreted.

At my request for statistical data bearing upon Nain health, the IGA Nurse created her own categories of illness, using her log as the primary source for all conditions she had treated in the period 1971-1972. Prior to my request for statistical information, she had had no need to develop categories, merely entering an account of each patient treated on a daily basis in her log book. Her statistics reflect only the total number of patients seen each month for each category of illness. Thus, rates of illness for each social group in Nain could not be determined. Since approximately 550 persons of the total population of 650 people living in Nain are either Inuit-Settler or Inuit, however, one can, with caution, interpret rates appearing on the following pages as approximating the kind and degrees of illness experienced by them. It was my impression that in certain categories, minor cuts and burns, headaches, common colds, and the like, Whites constituted a larger percentage of the total number treated at the nursing station than the Inuit-Settler/Inuit population.

Both Schaefer and Willis carried out work among Northwest Territory Inuit populations, approximately a decade apart. Neither use categories that resemble those of the IGA Nurse in Nain, but there is a similarity between categories used by each man even though they are not identical. Willis obtained his statistics from missionaries, nursing stations, RCMP, public administrators, census bureau statistics, and

and personal observation. Schaefer, on the other hand, obtained statistical data drom extensive firsthand observation and testing as well as nursing station and other investigators' findings. Willis based his rates on incidence per 100,000 population of Northwest Territory residents, while Schaefer is not consistent in the way he accounts for his rates (Willis 1963: 747-768; Schaefer 1973: 196-204).

In view of the lack of uniformity in categories used to account for illness and the means by which statistical data were arrived at, the following observations and comparisons must be viewed as general only and seen to approximate the conditions of health among Inuit of the Northewest Territories as well as Nain.

A. Accidents and Violence

Accidents and violence constitute the major cause of morbidity and mortality in Nain as in all Inuit people. In the Canadian Northwest Territories in 1962, Willis reported 17 per cent or more of all deaths were found to be due to accidents and violence. Morbidity rates compiled in the same study indicate illness due to accidents and violence were reported for 98 per 1,000 population, and represented the leading cause of morbidity and mortality, but gave no rates for the increase.

If one considers only ski-doo and hunting accidents in Nain, then the rate is approximately 19 per cent, or 126 persons in the community, and corresponds closely to the 1962 rate for other Canadian Inuit. Accident-related illness in Nain other than ski-doo and hunting accidents are as follows:

1. Cuts: Cuts received from ice, glass, knife, or any other source were treated for 45 per cent of the population of Nain, or 298 persons over a twelve-month period. The Inuit-Settler/Inuit do not consider cuts to be serious except in certain contexts associated with a curse, i.e., one minor cut is seen to be normal, while a series of minor cuts received within a relatively short period of time is seen to be indicative of a curse having been placed on one. If one is seriously cut then there is no hesitancy to go directly to the nursing station for treatment. If a serious cut is incurred while outside Nain, then whoever is available will suture the cut with whatever materials are at hand. Only if the cut results in dismemberment or permanent impairment will it be considered serious by Inuit-Settler or Inuit.

2. Burns and Scalds: Burns and scalds incurred from water, fire, frostbite, and other sources were reported by 28 per cent of the population of Nain, or 184 persons. Burns are also ignored unless they are quite serious. There are situations in which even extremely severe burns will be looked upon as having had a beneficial effect (see the case history of Ellius in Chapter Five.) Burns or scalds, like cuts, that are thought to threaten one's ability to function, are quickly reported to the IGA nursing station.

I was unable to obtain figures on the number of accidents which were alcohol-related, but Schaefer established that alcohol was a factor in most cases of accidents and violence he studied in the Northwest Territory. The IGA Nurse in Nain confirmed that the exceedingly high rate of alcohol use did contribute substantially to accidents and injury to self and others, although she had not kept records demonstrating that relationship.

B. Respiratory Diseases

Willis' 1962 study shows that 28 per cent of all Canadian Northwest Territory Inuit deaths occurred from pneumonia with roughly an additional 5 per cent occurring from tuberculosis and other respiratory diseases. In other words, approximately 33 per cent of all deaths of Northwest Territory Inuit at that time were from respiratory diseases. Morbidity as a result of respiratory diseases in the same study indicated about 18 per cent of all sickness resulted from respiratory diseases. Schaefer stated that disease and death from tuberculosis had declined by 1973, but new cases of tuberculosis among Northwest Territories Inuit were still 40 times the rate of new cases in southern Canada.

In Nain, the IGA Nurse incorporated tuberculosis as well as other respiratory diseases under a category labeled "Chest Infections." The only separate rates given by her were for influenza, colds, bronco-pneumonia, and bronchitis. "Chest Infections" were reported by 420 individuals or 55% of the total population. This is obviously quite high, about 15 to 20 per cent higher than that reported for the Northwest Territory Inuit in 1962 by Willis. Some of this discrepancy is undoubtedly due to the difference in the categories used. Breakdowns for respiratory ailments other than "Chest Infections" listed by the IGA Nurse were:

1. Colds: Colds are considered practically a normal condition in Nain, thus 12 per cent reporting to the nursing station with colds leaves some doubt regarding accuracy. Some portion of this 12 per cent could reflect the frequency with which Whites in Nain reported common

colds to the nursing station; it might also be accounted for in that these were later found to be associated with other conditions and recorded under another diagnostic label. Colds are usually "non-reportable" conditions which are treated indifferently by Inuit-Settler/Inuit.

2. Influenza: Influenza was reported by 301 individuals during 1971-1972, or 46% of the population. It is seen by the Inuit-Settler/Inuit population as a serious condition and they rarely delay in seeking treatment from the IGA station.

3. Bronco-pneumonia: Bronco-pneumonia was reported by 53 persons, or 7 per cent of the population. Unlike their fear of influenza, Inuit-Settler/Inuit often mistake the symptoms of Bronco-pneumonia with those of a common cold and allow their condition to progress to a serious stage before going to the nursing station for aid.

4. Bronchitis: Bronchitis was reported by 29 persons, or 4 per cent of the population. This condition, like Bronco-pneumonia, is often ignored until it interferes with their ability to function, at which point assistance is sought from the IGA nursing station.

It is my opinion that despite the high statistical rate of respiratory diseases accounted for by IGA records, it is inaccurate as a result of the unreported cases and does not reflect the actual incidence of respiratory disease in Nain.

C. Other Conditions

1. Skin Diseases: Skin diseases affect large numbers of individuals among the Nain population. Northwest Territory Inuit experience

diseases of the skin and cellular tissues as the sixth most frequent cause of all diseases reported with a rate of 98 per 1,000 population. In Nain, the rate for such conditions is significantly higher.

Scabies is wide-spread in Nain, said by the IGA Nurse to seemingly affect the families of mixed blood more seriously. Rates were not given for the actual cases of scabies, but were for impetigo, which often accompanies scabies. Six-hundred and thirty-five cases of impetigo were treated in Nain in 1971-1972. One is surprised to encounter individuals without impetigo in the community. Overcrowding and the absence of an adequate water supply make effective treatment of this condition an almost impossible task. In addition, eczema was reported by 125 persons, or 19.9 per cent of the population. Skin diseases are usually (in the absence of other symptoms) not considered to be serious by Inuit-Settler or Inuit. They are reported nonetheless because skin diseases interfere with one's functional ability. Additionally, such conditions are in most instances poorly understood by the Inuit-Settler/Inuit, having been introduced as a result of contact, e.g., new forms of bacteriolytic viruses, changes in diet, clothing, etc.

2. Ear, Eye, Nose and Throat

a. Ear: A 1961 survey of the Mackenzie Delta native population disclosed that 51 per cent of 731 patients examined had diseases of the ear and mastoid processes. Four hundred and sixteen persons in Nain, or 63 per cent of the community reported ear problems during 1971-1972. Nain's rate for ear diseases is basically in line with the findings from other Inuit populations. The nurse in Nain said that these 416 cases were primarily "runny ears" -- often associated with middle ear disease -- although she denied the presence of middle ear disease when I questioned her on this point; she attributed perhaps 3 per cent of the ear problems reported to be mastoid problems.

b. Eye: Eye problems represented 221 cases reported during the period, or 30 per cent of the Nain population. These conditions included conjunctivitis, snowblindness, and objects in the eye. This appears to be higher than rates reported for Northwest Territory Inuit, for whom eye problems represented about 19 per cent of all conditions reported. Eye conditions, like skin diseases are reported promptly as a rule by Inuit-Settler/Inuit because such problems bring about an immediate change in the performance of one's duties.

c. Throat: Tonsilitis was responsible for 245 cases reported to the IGA station, representing 32 per cent of the population. This ranks somewhat higher than the rate found among Northwest Territory Inuit. Although Inuit-Settler/Inuit tend to wait until tonsilitis has progressed markedly before reporting, they do report this condition to the nursing station when it can no longer be ignored.

3. Venereal Diseases: Until recently gonorrhoea and syphillis were confined almost entirely to the tree area of the north amongst Indians and Whites, rarely was an Inuit case seen. Now the condition has become a serious health problem in many parts of the Arctic affecting large numbers of Inuit. The rate of gonorrhoea Willis reported in 1962 for the Northwest Territory Inuit was about eight times that of the all-Canadian rate. Schaefer's 1973 study did not give current rates, but he did indicate that venereal disease had greatly increased for the population in the last decade.

No syphillis was recorded among the Nain population at the time of the study, but gonorrhoea was reported in 112 persons, or 19 per cent of the population. Gonorrhoea is not perceived as serious by Inuit-Settler/Inuit, nor is it promptly reported to the nursing station (see case history on the subject of venereal disease in Chapter Five).

4. Nutritional Diseases: Scurvy is usually not found among Inuit populations except when the native diet is abandoned and "White" food of a poor quality becomes the basic diet. In Nain, twenty-six persons, or 3 per cent of the community, were diagnosed as having scurvy during the twelve-month period used by the nurse to delimit cases reported. The relationship between nutrition and dental health could not be established due to the absence of statistics on dental care in the community (the only dental care available in Nain is for the purpose of extracting seriously defective teeth; this is performed by the IGA Nurse). Each summer an IGA ship comes to Nain with a dentist (and other medical personnel) on board; if one is in Nain during that period it is possible to have teeth filled. As I will indicate in Chapter Four, most people are not in Nain during these summer months, so the few who obtain preventive dental care are an exceedingly small per cent of the total population.

5. Mental Disorders: Little was available on the kinds of mental disorders observed at the IGA station in Nain. The total number of cases recorded by the IGA Nurse in this category totalled less than 1 per cent of the population. This is a surprisingly low number of mental disorders in any population. It does not reflect the actual number of cases in the community because most were treated under traditional techniques and never reported to the nursing station. Reporting an individu-

al with a mental condition to the IGA station is the final sanction -- for one who has failed to respond to traditional healing techniques -- now that execution is illegal (Mowatt 1975: 186-222).

VII. SUMMARY

In the foregoing chapter I have shown that although Nain Inuit define rather clearly those behavioural traits they see as requisite to mental health, criteria elicited for physical health were less explicit. This paucity of data bearing upon physical health reflects not only a less formally structured position of physical illness within the health domain than that occupied by "mental conditions," but that mental health is more crucial to the "negotiating collectivity" as a regulatory mechanism.

In contrast, the nursing station personnel is worried about physical health, especially at pandemic levels that continue to elude the efforts of IGA personnel to bring under control. In health as well as illness, the model for "mental conditions" was both salient and highly structured, received a great deal of attention from the community, and was still -- for all purposes -- essentially traditional. The model for physical health, to the contrary, was less organized taxinomically, received a matter-of-fact treatment in the daily lives of Inuit-Settler/Inuit, and showed a greater degree of borrowing of terms and concepts from western medicine.

It is highly significant that where traditional concepts and treatment persist, the incidence of mental illness is low, perhaps reflecting the successful integration of crucial traditional concepts, over time, into the Inuit medical model. It serves to treat those who become subject to a "mental condition" and as a social mechanism, both creating and maintaining a milieu in which "mental conditions" are to a large extent prevented from developing.

Conversely, where traditional concepts and treatment have undergone considerable modification -- to reflect those of western medicine -- the incidence of physical illness and trauma is exceedingly high. This can be explained in that the adoption of ideas from western medicine has resulted from instrumental, not integrative goals, for Inuit-Settler/ Inuit. For some years changes relating to illness have been the result of negotiation of illness by powerful individuals in the community; increasing power among non-Inuit sectors of the "negotiating collectivity" have understandably influenced the adoption of western medical concepts and practices in the realm of physical sickness.

Culture change, as previously stated, does not merely place the medical model of a subject culture in static opposition to that of a dominant culture, but creates an atmosphere wherein two or more models of medicine are engaged in a dynamic relationship, out of which changes in perceptual categories, diagnostic criteria, and treatment occur over time. Changes resulting from interaction of this kind may, but need not prove disastrous to the subject culture. The key to the successful resolution between competing medical models would seem to rest upon the dominant culture's understanding of the linkage existing between the subject culture's medical system and its other social institutions. In the case of Nain Inuit, such enlightenment on the part of the agents of western medicine (and other EuroCanadian administrators) has not existed;

it has been the Inuit's own initiative and social work through the "negotiating collectivity" that has thus far allowed maintenance of some aspects of their own system of medicine along with acceptance of particular features of the western model of medicine.

HISTORY AND SOCIO-ECONOMIC ORIENTATION OF NAIN'S POPULATION

CHAPTER FOUR

I. INTRODUCTION

Subject matter that in some contexts would be disjunctive, of necessity is treated as a single unit in this chapter. I found decisive evidence that Inuit -- and to a large extent all social groups in Nain -- consider a configuration of cultural, ecological, demographic, physiological and psychological entities when faced with the reality of illness. Only Inuit-Settler/Inuit cognitively linked these features to *explain* illness, but all groups included these variables when they had to decide upon a course of action to be followed in specific episodes of illness. Hence, functionally there are only two social groups vis-a-vis health in Nain, i.e., Inuit-Settler/Inuit and Settler/White.

The principle reason for this linkage would appear to be the particular ecological and demographic factors that operate in this and other sub-arctic and arctic environments. No brief description of environmental features in isolation from the history, the socio-economic orientation of each social group, nor the dynamics of the "negotiating collectivity," could adequately explain what takes place in the community in situations of illness. It is for this reason that contingencies which impinge upon the community as a result of its geographic location are considered first in this chapter.

Following a description of the environment, a reconstruction of Nain's history since contact outlines the set of circumstances that have given rise to each social group, and to some extent the socio-economic orientation of each. Roles of authority that operate in each social unit, and the nature of such roles as they bear upon health matters, are examined under the section that deals with each social segment. The mediations of the IGA Nurse and the akiterijuq, "native healer," was seen to have the greatest significance of any within the "negotiating collectivity" and because of this their roles are given separate and extensive treatment in the final portion of the chapter. The continuity of events that began with contact and developed over time are depicted as they have affected the domain of health, up to, and through, the period of fieldwork. The death of the curer has undoubtedly modified this substantially.

II. GENERAL DESCRIPTION OF THE ENVIRONMENT

Labrador is dominated by mountain ranges from latitude 56° 30' on the north. These ranges fall into three main groups: the Kiglapaits, whose name signifies in Inuktitut "saw-tooth" mountains, lie just north of Nain; the Kaumajets, or "the ones that are shone upon" are situated sixty miles farther north near Cape Mugford; and the Torngats, or "home of the spirits" extend from Saglek Bay for 150 miles northward to the island of Killinek, which caps the peninsula at the entrance to Hudson Strait (Forbes 1938: 188; Wheeler 1953: 38, 48, and 88; Tanner 1944: 202-223).

Labrador could be said to be a lake district. These lakes attest to its late glaciation with raised terraces, deep mountain tarns lying in the interior, and peculiar lunoid furrows hollowed from rock along the coast where once great glaciers entered the sea. Now these furrows form shallow lakes and account for the water supply found on many of the outlying islands (Packard 1891: 16-17; Forbes 1938: 209-211); personal observation 1971-1972). These islands are situated all along the Labrador coast, but Nain probably has more than any other community with approximately 500 making up her archipelago (this refers to the entire Nain bight) (Kleivan 1966: 14).

Nain temperatures may dip as low as 40°F. in the night during the summer months while rising to above 70°F. during the day. Winter temperatures are as low as -52°F. although for certain periods during the winter, temperatures may rise to 0°F., or slightly above. The interior, or "backcountry" is much colder than the coast (Forbes 1938: 155-157; Kleivan 1966: 16; personal readings 1971-1972).

Valleys surrounding Nain are forested with black spruce, tamarack, white spruce, balsam fir, birches, willow, and alder (Tanner 1944: 369-395).

Berries used by Nain inhabitants as a source of important nutrients are:

Kiuu.tani'nnuk	Blueberry	Vaccinium Pennsylvanium
aqpiu.yuk	Indian Pear	Amelanchier Canadentis
po'nnuk	Dewberry	Rubus articus
kimi.nau'yuk	Dogberry	Ribes Cynosbati
sin'atuk	Ground Blueberry	Viburnum caespitosum
qa'qtu'lik	Frothberry	-
a'kpik	Bakeapple	Rubus Chamaemorus
mama'qtu'lik	Maidenhair-berry	-
a.riti'natuk	Wild Strawberry	Fragaria virginiana
ponno'yuk	Foxberry	-
kiminu'k	Partridgeberry	-

Both arctic and subarctic fauna make up the wide variety of animals used as food by the Inuit-Settler/Inuit. Most important of the sea animals are the ne'tceq or "Jar Seal" (Pusa hispida) and Hiyolik or

"Harp Seal" (Pogoplulus groenlandicus) although others are known and obtained on a less frequent basis: the *u'djuq* or "Square flipper" (Engnathus barbatus), the *kas.i.yiak* or "Ranger Seal" (Phoca vitulina), the *ap'puk* or "Bladdernose Seal" (Cystrophora cristata), and occasionally the *killilu'yuk* or "White Whale" (Delphinapterus leucas) (Tanner 1944: 426-428; Nain informants 1971-1972).

Of the land animals, *tuk'tuk*, or the "barrenground caribou" (Rangifer arcticus) occurs in substantial numbers. One herd spends the summer between Nachvak and Nain. Among the smaller food animals to be found are *ookalik*, "arctic hare" (Lepus arcticus), *ila.usiak*, "Porcupine" (Erethizon dorsatum) and *tinguniak*, "fox." *Us.luk*, "Black bear" (Ursus maritimus). The major kinds of fish to be found in this area are *ugat.suk*, or "tom-cod" (Boreogadus saida), *kauvisillik*, "salmon" (Salmo salar), and *ika.luk*, "arctic char" (Salvelinus alpinus). Water fowl and land birds constitute another important source of food among Nain Inuit.

II. HISTORY OF CONTACT

A. *The Moravian Period* (1771-1871)

Jens Haven, a Moravian missionary, founded the first mission station in Nain in 1771, initiating an activity which was to have implications of the greatest importance for the form acculturation among Labrador Inuit would take (Gosling 1910: 251-316). The second social group in Nain, those identified in this study as "White" originate from this period.

The Inuit men's association, or Qaggi, was established in the same year the Moravians persuaded Inuit living in the surrounding area to move on to the station. From this, one can trace the beginnings of the "negotiating collectivity" to the year of contact, 1771.

Major changes initiated by the Moravians in this period were the institution of the commercial cod fishery and the elimination of the autumn caribou hunt. Technological changes during this early period were seemingly few: introduction of European tools, wooden boats, fish nets, and rifles, but these were significant in that they contributed directly to the overuse of natural resources in that region.

Little change occurred in the basic form of land transportation. The komotik, or sled, used before contact, underwent very little change; the use of dog teams -- from five to seven animals harnessed to different length traces so that they run one behind the next -- was similarly unchanged (Hawkes 1916: 64-68; Tanner 1955: 299). The only change that can be inferred from the literature to be associated with the komotik would have been related to the introduction of European tools, such as the saw, which were adapted for purposes of komotik construction; this allowed runners to be cut from the same tree and in general made construction easier.

The umiak, or "Woman's boat," used by Labrador Inuit in moving households over long idstances and in hunting large game (Hawkes 1916: 68-69) was the first form of transportation to be replaced. Missionaries reported that by 1860 the umiak had virtually been replaced by European wooden boats. The kayak was to persist for a much longer period of time (Hawkes 1916: 68-73).

Nets were not an integral part of the original fishing equipment, but were first introduced by the missionaries in 1772 (Kleivan 1966: 48). Gosling claimed, on the evidence of mission records, that in the summer of 1772 the missionaries taught the natives to use nets instead of spearing fish. Fishing activity prior to the coming of the missionaries was most likely restricted to subsistence fishing for salmon in the rivers, lakes, and along the coasts. From the first days of their arrival in Labrador, Moravian journals reflect the mission's awareness of the economic importance commercial cod fishing held for the mission, and exerted pressure upon the Inuit to engage in this new activity, although with little success at first.

A complex set of circumstances soon acted to force Inuit into participating in the cod fishery, nonetheless. First, the acquisition of rifles for hunting and the consequent great slaughter of caribou resulted in overkill and the decrease of caribou. As a result, Fall hunting was often unproductive. Secondly, there developed a dependency upon the mission stores in order to secure food to replace that which was lost by failure to obtain meat from the autumn caribou hunt. Supplies from the mission stores had to be paid for and it was not long before the missionaries convinced the Inuit that a longer cod fishing season would give the Inuit the necessary income to buy their supplies (Kleivan 1966: 53; Freeman 1974 personal communication).

B. Fisheries Period (1871-1926)

Newfoundland fishermen had ventured as far north as Nain to trade with the Inuit prior to 1871, but these were for the most part individual traders. By 1893 there were in excess of 1,000 vessels engaged in fishing in the area north of Hopedale alone (Packard 1891: 240; Kleivan 1966: 188; Gosling 1910: 413-431). The mission's lucrative revenue from the cod fishery naturally suffered as a result of this kind of competition.

The Inuit also had increasing contact with Whites who were moving to northern Labrador communities by this time in search of new fishing and hunting territory. Inter-marriage between the two groups characterized their relationships from the outset (Gosling 1910: 276, 284, and 420). It is at this point one sees the emergence of the third social group in Nain, the "Settlers." Missionaries perceived this group as distinct from the Inuit, and consequently Settlers were favored in matters of economics and education. Other factors that set them apart as a social unit related to economic benefits received from their freedom to trade with Hudson's Bay Company stations outside of Nain (a freedom not allowed the Inuit by the missionaries). Settlers could obtain better prices for their products from the Hudson's Bay Company and could purchase at a lower cost than the mission demanded from the Inuit (Kleivan 1966: 127). Educationally, Settlers profited because until 1950 the Moravian school taught Settler and Inuit children in separate classes and only Settler children learned English. Since English was a prerequisite to higher education in the south of Labrador, only Settler children could receive the benefits that accompany higher education.

Between 1871 and 1926 the seasonal economic cycle underwent still futher changes. One important change was the increased use of the mission boarding school by Inuit parents to leave children while they undertook sealing activities. This contributed to a breakdown in the transmission of traditional hunting techniques to younger generations, and exposed children to intensive acculturation through their perpetual exposure to mission authority and its associated norms.

Another change involved the extension and intensification of the cod fishery in response to the previously mentioned competition. The komotik remained the same throughout this period, although by now European boats had completely replaced the umiak. Cod-traps were not yet in use although gill-nets introduced by missionaries were by now in extensive use. There were no significant changes in hunting equipment following the introduction of rifles in the preceding period. Trapping, however, took on a new commercial importance during the latter part of this period.

C. Hudson's Bay Company/Confederation/Division of Northern Labrador Affairs (1926-1972)

Due to the growing difficulties with trade activities as a consequence of the outside competition for the cod fishery, the mission allowed the Hudson's Bay Company to take over its stores for a period of sixteen years beginning in 1926. Then, prior to Confederation in 1948, the Newfoundland government took over the stores from Hudson's Bay Company at all locations along the Labrador Coast (Kleivan 1966: 128-129).

As a result of a decline in cod on the world market, the Newfoundland government found it economically unfeasible to service northern Inuit communities -- their primary reason for having previously done so was related to their need to transport cod from each Inuit community to Newfoundland for sale or export -- and in 1959, relocation of Inuit from these northern villages was begun.

This population's exposure to agents of contact had been decidedly less than that of Nain Inuit, and are the "Inuit," the fourth and largest social group living in the community of Nain today. Differences in the two groups of Inuit (Nain Inuit and newly relocated Inuit from northern Labrador) are well understood from a mission account in 1939:

> "In Hebron we are working among a people, many of whom are little removed from their natural state and were only baptized when adults. There is a vast difference between the Hebron and southern Eskimos. They are made up of Ramah, Nachvak, Killinek and Autlatsivik people..." (Periodical Account 1939: 124-125).

Two distinct seasonal economic cycles existed for the period between 1926 and 1972. The first covers the activities of the Hudson's Bay Company from the time of its takeover in 1926 to its closure in 1942; the second period includes changes resulting from the takeover of mission stores by the government of Newfoundland in 1948 to the time of this study in 1971-1972. I have differentiated between these two periods by labelling the first "Fur-Trapping," and the second, "Government Subsidy."

1. Fur-Trapping 1926-1942: By late November entire families set out for their trapping territories; children were taken out of school frequently to accompany parents in order to extend the family's trapping territory through sheer numbers of individuals. This was necessary as a result of Hudson's Bay Company's strict policy with regard to credit, and by this time the native population was almost totally dependant upon such food and supplies. Accessibility to credit was based entirely upon one's yield of furs. The effort required to ensure sufficient credit for a family's survival resulted in the winter sealing being neglected, the abandonment of both the autumn and February caribou hunts, and spring

sealing was carried out on a hit-and-miss basis. The only season which was not disrupted by trapping was the summer fishery, and that, of course, was due to the fact that trapping cannot be carried out during summer months.

2. Government Subsidy 1942-1972: The takeover by the Division of Northern Labrador Affairs of mission stores was followed by a period of disorganization and the inability of the population to earn sufficient income due to the drop in the fur trade. Neglect of the fishery to some extent, and to sealing and caribou hunting, to a larger extent, left Nain's seasonal cycle a fragmented image of former patterns upon the withdrawal of the Hudson's Bay Company. The forties were, in spite of this, economically safe due to the Second World War and the construction of air bases in southern Labrador. Many Inuit traveled south to these bases where they worked throughout most of the war years.

It is inferred from these events that the input of northern Inuit on an already depressed economy in Nain resulted in an increased dependance on welfare subsidy.

Kayaak were finally abandoned for the motor boat in Nain in 1935 (Kleivan 1966: 47) although as one went north it was possible to find men using Kayaak until as late as 1955. The komotik remained essentially the same, but its means of locomotion was changed when in 1966 the first ski-doo appeared in Nain. Within two or three years almost every family used ski-doos to pull their komotik instead of a dog team. I could find only four functional dog teams in the community in 1971-1972. Notwithstanding the change to ski-doos for transportation, there were still 300 dogs in Nain as recorded in the DNLA Manager's census in the early part of 1972. This averages three dogs per family although the actual distribution was not on this basis. Some families refuse to part with their teams, even when their primary functional value has been lost, using them now as guard-dogs, e.g., for food and fuel caches.

IV. SOCIO-ECONOMIC ORIENTATION

A. Socio-economic Orientation by Group

The kind of socio-economic orientation typical of each social group at the time of the study and the relation of each to the "negotiating collectivity" is delineated on the following pages:

"WHITES"

Approximately thirty EuroCanadians, almost all of them adults, live in Nain. These individuals are representatives of outside agencies with economic and administrative control over the Nain population. They are responsible for the Northern Labrador Stores, International Grenfell Association nursing station, Moravian Mission and its school, and the Royal Canadian Mounted Police. Internal dissension exists within and between each agency despite the necessity of its members to cooperate at some level to maintain control of the subject culture. With the exception of the Moravian Missionary, his sister the School Principal, and the IGA Nurse, these individuals speak only English. In the opinion of those Inuit with whom I spoke -- all informants and several others additionally -- even the Moravians' knowledge of Inuktitut is limited to dialogue requisite to the performance of their official duties and they are not considered to be linguistically competent outside those spheres.

Participation in hunting activities is for all purposes absent among this group. White males venture into the surrounding countryside to carry out rescue missions or brief surveys, and then only with ample assistance from Settler, Inuit-Settler, or Inuit males.

EuroCanadians living in Nain, with one exception, establish their residence in the southwestern part of the community (see Area A in the town plan in Appendix III). The only EuroCanadian living in a part of the community other than the southwestern portion is the minister of the Moravian Mission. His home is situated in the exact center of the community on the edge of the northern boundary (marked in red, and almost completely in line with the pier). A northeast-southwest orientation was found to operate in the determination of residence location. Northeast is Inuit, southwest is K'adlunat, "White." Applying this fundamental axis to the layout of houses in Nain, one sees how social groups reflect spatially the major cultural orientation of its members.

Whites confine social interaction almost entirely to other EuroCanadians, with infrequent social contact with some, but not all, Settlers. Visits between Whites and Inuit-Settler/Inuit are for reasons associated with the formal duties falling within the Whites' jurisdiction.

Several Whites are members of the "negotiating collectivity" and have significant authority in relation to health; only that part of their authority that bears upon matters of health is considered. They are:

DNLA Store Manager: The DNLA Store Manager has authority in two main areas, community sanitation and community safety. Sanitation-related services such as garbage collection, sewage disposal, and water supply fall within his jurisdiction, all of which bear upon disease prevention.

Safety procedures to be followed on work projects, the supervision of work projects, control of dock procedures and all water traffic entering and leaving the Bay of Nain, similarly are his responsibility.

In times of community emergencies he is expected to cooperate with the IGA Nurse to allocate manpower and to implement procedures outlined by her.

DNLA Fishplant Manager: This role affords restricted, but important authority in relation to health. This individual employs large numbers of the population during the summer months, indirectly, those who fish along the coasts to supply the plant's product, and directly, most of those remaining in Nain to work in the plant. He has responsibility for setting and enforcing safety measures in the fishplant, enforcing hygenic practices associated with all stages of food processing, and quality control.

The Moravian Minister: This person has no formal authority to regulate matters of health, but wields tremendous power indirectly through his efforts to direct the moral behaviour of all who live in Nain. In this way he exercises power in matters of alcohol consumption, child-abuse, wife/husband beating, sexual conduct, and so on. Through his ties with the school and the IGA Nurse he exerts considerable influence upon the course followed in various health-related matters.

Moravian School Principal: Most authority in this role is confined to enforcing health standards for children attending school that are set by the IGA Nurse, or, in accordance with religious precedents of the Moravian church. The school is an important referral system through which children observed to have health problems are sent to the nursing station for treatment. In this capacity both the principal and the teachers employed by the school play a significant part in detecting health problems in children betwen the ages of six and fifteen years of age.

The RCMP Constable: This role has little explicit authority with regard to health except to implement standards implied by Canadian law and the community. The Mountie intervenes in activities which threaten the individual's life or health when such events are brought to his attention. Much like the Moravian minister's form of influence, the RCMP effects health through intervention in serious cases of alcohol abuse and the like. Differing from the minister's efforts in this direction, the RCMP acts only when abuse results in marked damage to persons or property. In the event of a community health crisis, he too, becomes involved in carrying out procedures outlined by the IGA Nurse.

"SETTLERS"

Individuals identified as Settlers number approximately 70 persons (all ages included in this figure). English is their first language and most, but not all, speak Inuktitut as their second language. Unlike the Whites, many Settlers are said by the Inuit-Settler/Inuit to speak fluent Inuktitut.

Unless employed in one of the few year-round positions in Nain, Settlers follow a typically Inuit ecologic adaptation. They hunt, fish, and engage in sealing activities just as the Inuit, with one difference. Maps showing seasonal distribution of population on pages 112, 113, and 114 illustrate the essential difference to be that Settlers restrict their activities to points close to Nain. Hunting of caribou rarely exceeds a total distance of 100 miles round-trip; fishing is restricted to long established bases on nearby islands or bays, e.g., Black Island, Voisey's Bay, and Webb's Bay, where Settlers have constructed second homes they occupy during the fishing season. Sealing is also carried out in areas within a comparatively short distance from the village itself. Subsistence techniques differ little if any from those employed by the Inuit, except the approach is seemingly more intensified in any

Figure 1. Caribou Hunting Areas

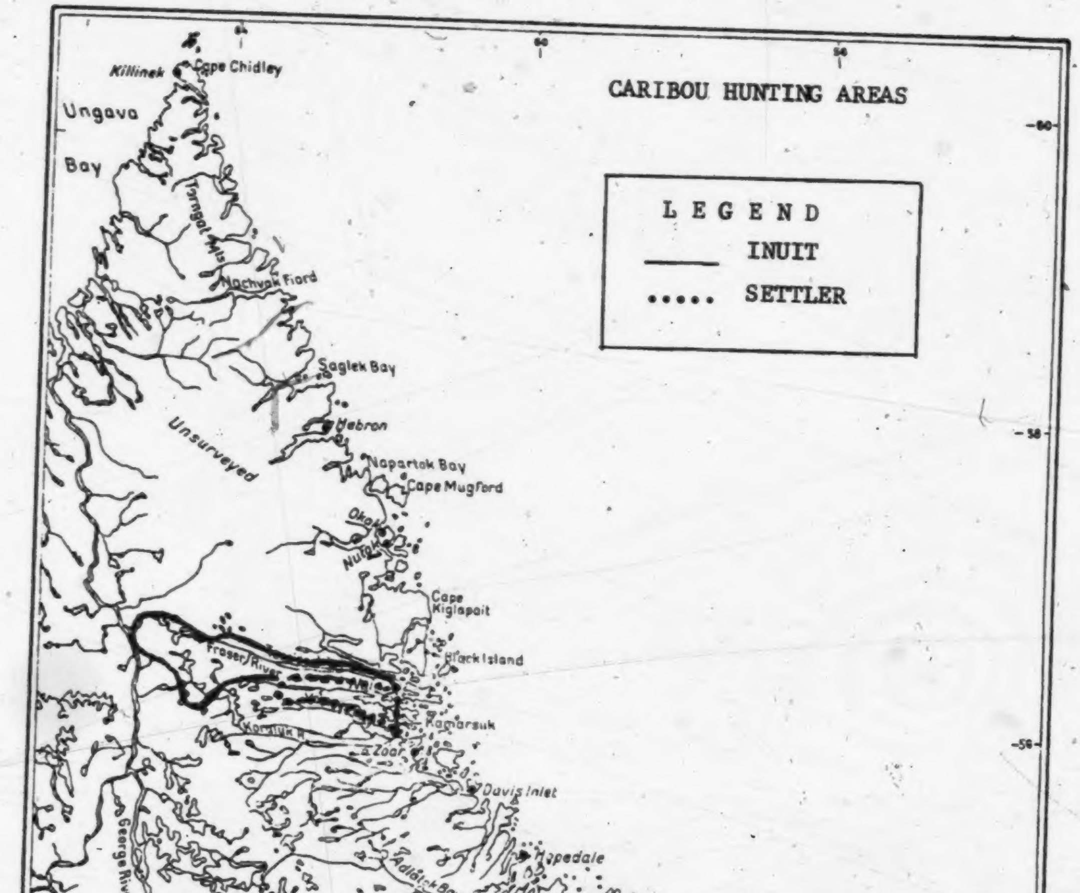
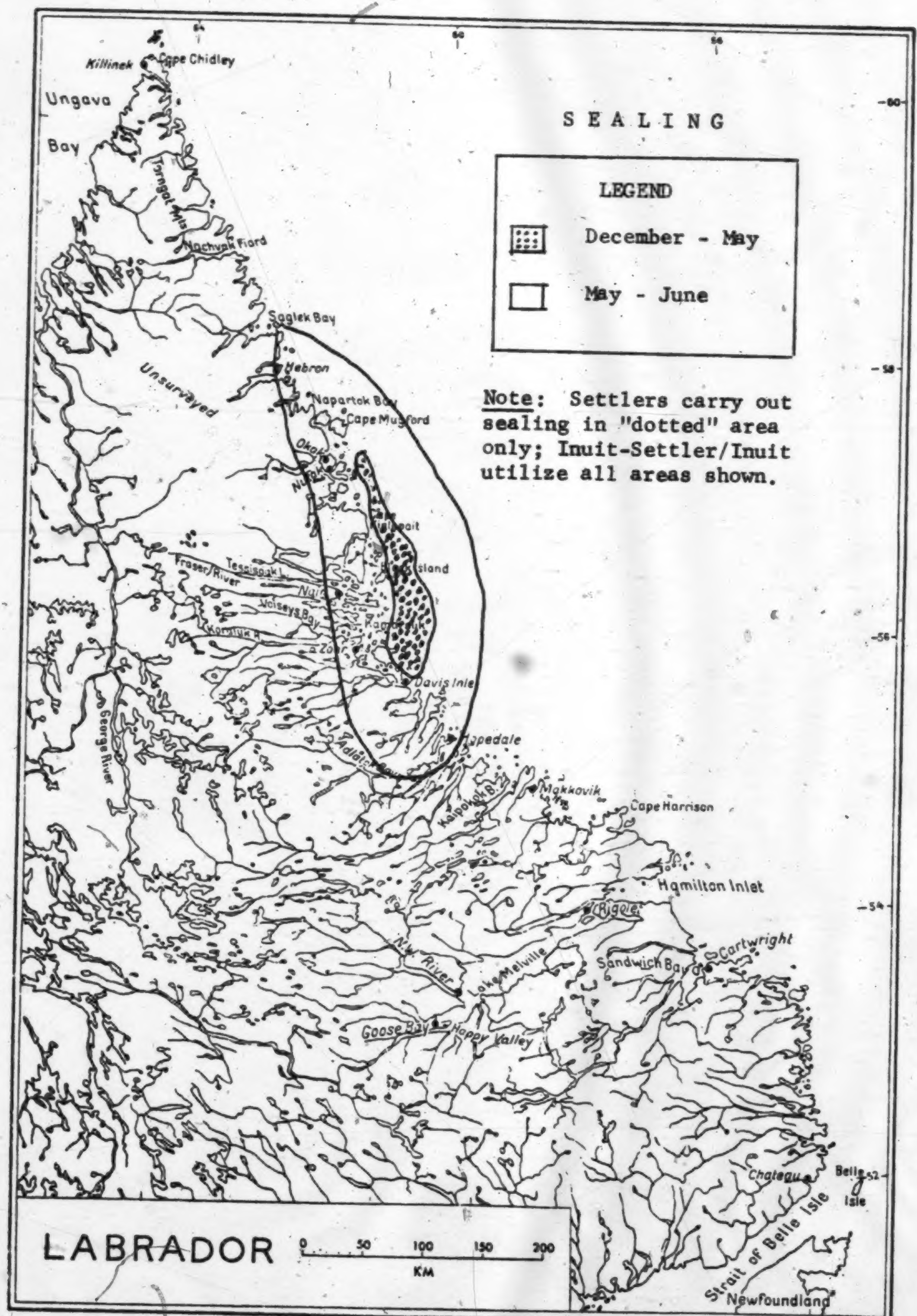

CARIBOU HUNTING AREAS
LEGEND
INUIT
SETTLER
LABRADOR
0 50 100 150 200
KM
Killinek
Cape Chidley
Ungava Bay
Torngat Mts
Nachvak Fiord
Saglek Bay
Hebron
Unsurveyed
Napartok Bay
Cape Mugford
Okak
Nutak
Cape Kiglapait
Black Island
Fraser River
Kamarsuk
Zoar
Davis Inlet
George River
Hopedale
Adlatok Bay
Kaipokok B.
Makkovik
Cape Harrison
Hamilton Inlet
Rigolet
Cartwright
Sandwich Bay
N.W. River
Lake Melville
Goose Bay
Happy Valley
Chateau
Belle Isle
Strait of Belle Isle
Newfoundland
60
58
56
54
52

Figure 2. Sealing Distribution



SEALING

LEGEND

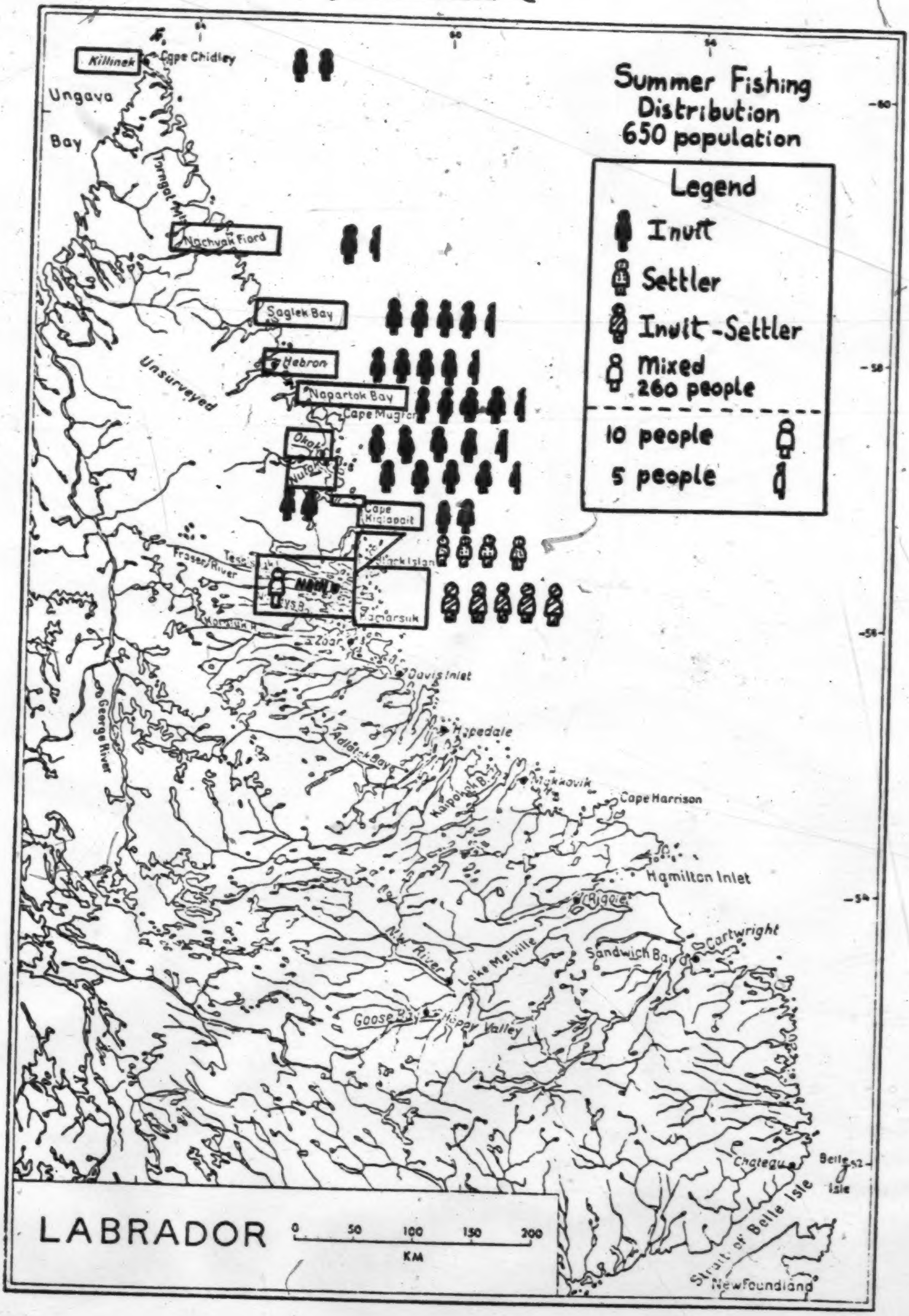
▦ December - May

☐ May - June

Note: Settlers carry out sealing in "dotted" area only; Inuit-Settler/Inuit utilize all areas shown.

Killinek
Cape Chidley
Ungava
Bay
Torngat Mts
Nachvak Fiord
Saglek Bay
Hebron
Unsurveyed
Napartok Bay
Cape Mugford
Okak
Nutak
Island
Tessisoak L.
Fraser River
Nain
Voiseys Bay
Davis Inlet
Hopedale
George River
Makkovik
Kaipokok B.
Cape Harrison
Hamilton Inlet
Rigolet
Cartwright
Sandwich Bay
Lake Melville
Goose Bay
Happy Valley
Chateau
Belle Isle
Strait of Belle Isle
Newfoundland
LABRADOR
0 50 100 150 200
KM
64
60
56
60
58
56
54
52

Figure 3. Summer Fishing Distribution


Summer Fishing Distribution
650 population
Legend
Inuit
Settler
Inuit-Settler
Mixed
260 people
10 people
5 people
Killinek
Cape Chidley
Ungava
Bay
Nachvak Fiord
Saglek Bay
Hebron
Unsurveyed
Napartok Bay
Cape Mugford
Okak
Nutak
Cape Kiglapait
Black Island
Nain
Tessiujak
Fraser River
Kamarsuk
Zoar
Davis Inlet
George River
Hopedale
Adlatok Bay
Kaipokok B.
Makkovik
Cape Harrison
Hamilton Inlet
Rigolet
Cartwright
Sandwich Bay
Lake Melville
N.W. River
Goose Bay
Happy Valley
Chateau
Belle Isle
Strait of Belle Isle
Newfoundland
LABRADOR
0
50
100
150
200
KM
60
58
56
54
52

single expedition with the objective of stockpiling provisions, and thus reduce the numbers of trips required to supply their needs.

The more substantial economic base of the Settler can be attributed to his fraternization with, and preferential treatment by the White community within which economic power lies. Some day-to-day economic advantages of being identified as a Settler are the following: the loan of power equipment between Whites and Settlers is common, while the Inuit-Settler/Inuit is usually not so favored. Settlers receive more flexible credit terms from the local stores due to their sounder economic base. Most importantly, the better educational background of the Settlers, coupled with the economic and moral support they receive from Whites, allows for their increasing financial participation in Nain's economy. Settler-owned commercial establishments in 1971-1972 consisted of a coffee shop, a ski-doo parts shop, a clothing store, an appliance repair shop, a grocery store, and a home bakery.

No Inuit-Settler or Inuit had the financial support to engage in commercial economical activities. The one Inuit-Settler who attempted to do so opened a grocery-variety store, but the intensity with which his venture was undermined, resulted in the closure of his shop and bankruptcy proceedings brought against him within a brief period of time.

Settlers' homes are situated in Area B on the town plan. They occupy an area adjacent to the Whites at the southwestern end of the community. Visiting patterns are most intense among Settlers themselves. Unlike the Whites, there is visiting between Settler and Inuit-Settlers due to the extensive marriag ties. Work-related activities are carried out between men of the Settler group and men of both Inuit-Settler and

Inuit groups, but no other special interaction takes place between individuals of the Settler and Inuit population.

The only role of authority within the Settler community is that of the "Head" of the Community Council. This is the first Settler to have ever held this position. He was voted into office during the period of fieldwork, and seemingly had the support of the Inuit-Settler and Inuit communities. The fact that both his wife and mother are members of important Inuit-Settler families is undoubtedly among the reasons that account for the council's leadership being transferred to a member of the Settler group for the first time in history, for Settlers have little power access generally. The new Settler "Head" of the Council is, in reality, functioning as an Inuit-Settler/Inuit.

"Head" of the Community Council: The "Head" of the council does not actively pursue a course designed to ensure health in the community, but responds to specific situations when brought to his attention. This may be done informally, or formally by presenting the matter to the council during one of its regular sessions.

"INUIT-SETTLER"

These are the Inuit with longest residence in Nain. They number approximately 250 people. Inuktitut is their first language, but all speak English with varying degrees of proficiency.

Some few Inuit-Settlers obtain "token" jobs with the government store in the capacity of clerk, or disperser of stove oil, and the like (bookkeepers and those holding office jobs with the government store were all young Settler males). During the summer months Inuit-Settler males are employed as dock workers and, more recently, workers in the fishplant. For this reason, Inuit-Settlers are the least predictable in relation to their participation in various forms of traditional food harvesting. Those who hold year-round jobs, for example, undertake traditional forms of game harvesting in much the same vein as the urbanite who goes on an occasional hunting trip. During Spring sealing one sees what approaches the most organized efforts on the part of Inuit-Settlers to participate in traditional forms of hunting. In sum, the Inuit-Settler is more "settled" than his Settler neighbor.

There is a sub-group from this category of long term Nain Inuit-Settlers -- although as a group they act independantly of one another for the most part -- approximately 50 individuals, whose attitudes and technology remain more traditional. This group of Inuit-Settlers, like the Settlers, restricted fishing to intensive family endeavor among the islands off Nain instead of travelling to the northern fishing grounds. In the Spring, on the other hand, they did not confine their sealing to areas near Nain, but ventured far in their search for seals as did the Inuit; similarly, in hunting caribou they went the way of the Inuit, to the far reaches of the "backcountry."

Houses belonging to Inuit-Settlers are identified as Area C on the town plan. It is readily observed that Inuit-Settlers' homes have the least restricted distribution of any social group and are located in all areas of the community. Distribution of Inuit-Settler homes appropriately reflect their wide affinal and consanguinal ties with both Settler and Inuit groups.

Historically Nain's authority structure is old (see page 101), and in some ways represents an unbroken line predating Moravian contact.

Families moving on to the mission station in those early days relinquished their power at one level, that of policy-making. At another level, that of function, the Isumataq, "leadership by oldest males" continued to operate in spite of certain restrictions. Not surprisingly, then, roles of authority that exist within the Inuit-Settler segment of the community are the most numerous of any social group in Nain. The listing that follows includes all but those of the akiterijuq, "native healer," and individual members of both the Community Council and the Church Elders. As stated, the curer will be given separate treatment at the end of the chapter, while the latter two groups are not included since they do not act independantly of the organizations with which they are associated.

"Former" Head of the Community Council: Important role holders among the Inuit-Settler/Inuit community do not -- in the mind or behaviour of other Inuit-Settler/Inuit people -- relinquish their full authority when their term of office is over. Because of this the "Former" Head of the Community Council continues to be consulted in all matter effecting the community and acts in an unofficial capacity to regulate activities in Nain just as he did when officially holding office. Through him health matters will sometimes be negotiated and the issue brought to the attention of other influential persons in the community.

"Chief" of the Church Elders: The Chief Elder and members of the elders' consistory are active in much the same fashion as the Moravian Minister officially. They intervene only in morally-related behaviour that may in turn, effect health. The difference in their approach is worth note, for they do not simply repremind offenders, but instead, work with the family to alleviate problems that may come under the category of morally-related health problems. (I use the term "morally-related" from the perspective taken by the church in Nain).

"Former" Chief of Church Elders: This individual is quite old now, but like the "Former" Head of the Community Council still has tremendous powers within the community. In fact, his scope of power far exceeds that of either the

"Former" Head of the Community Council, the present "Head" of the Community Council, and the present "Chief" Elder of the Church. His preferred course of action in any health matter would have more weight than any other member of the "negotiating collectivity," with the exception of alliances that might be formed to override his preference, or those of the IGA Nurse and the akiterijuq.

Caretaker of the Dead: This person's function is restricted primarily to duties surrounding the death of all Inuit-Settler and Inuit in Nain. Since the handling of death continues to be quite traditional, he is called the moment anyone dies, and, in keeping with traditional practices, is the only individual who will come in direct contact with the dead. Since disease and infection are often a part of dying, this long-standing ritualized handling of the dead is seen to be a positive factor in preventing the spread of disease.

"INUIT"

The 300 individuals comprising this group are those who were relocated from northern Labrador communities to Nain. Inuktitut is their first language. Many but not all speak English as well.

Most individuals in this group follow the traditional forms of game harvesting. With the breaking of the ice they leave for fishing grounds in the north of Labrador (see page 113). These locations were found in almost every instance to be the original location from which the family came. Except for infrequent trips to Nain for supplies, families remain at these locations until the approaching winter ice forces them to head back to Nain. During October, November, and part of December they take part in the winter sealing. In February they participate in the caribou hunt. Spring sealing begins in March and some men still take their entire families along, returning to Nain just before the ice breaks to prepare, once again, for the summer's fishing.

Inuit homes are located in Section D on the town plan. This area, incidentally, is known by everyone in Nain as "The Village"; the community itself is never referred to in this way. The Shaman is included in this segment of the population, occupying the last house -- the most northerly situated of all the homes in Nain -- with his seven sons and their families located nearby. Relative northerliness of residence in "the village" corresponds to the relative position of one's former home area in most, but not all, instances. The home of the RCMP Special Constable (the only other role holder of importance in the "negotiating collectivity" from the Inuit community) occupies the most northeasterly located home in Nain.

Only two roles of importance, as I have mentioned, are to be found among the Inuit of Nain. Their influence, scope of authority, and ability to direct the course of action in all matters effecting the community, with health among them, cannot be underestimated. Of all the people in Nain who were known to be important in matters bearing upon health, the activities of these two men were the most difficult to investigate. An unmistakable reluctance to discuss either man was met on every occasion I attempted to gain knowledge of their activities (this included my own Research Assistant, the nephew of the RCMP Special Constable). Consequently, the role descriptions that follow reflect merely those forms of influence that could be determined through observation and limited informant contribution.

The RCMP Special Constable: Unlike the RCMP Constable, this Special Constable functioned in a more direct way to implement or curtail activities that effected health and community safety. He exercised tremendous power in his role, but not because of legal authority attached to his position; his authority was based upon his being highly respected and the fact that he was a "true" Inuit from the North. In short, he is the real authority by which "peace" is kept in Nain, He will, in most instances, be the first and sometimes the only person to intervene in cases of misconduct which are health-related. His handling of these matters act to perpetuate certain practices, or, conversely stop such practices, by taking the offending party to the RCMP Constable where they then become subject to Canadian law, or resolving the situation along lines used by Inuit to maintain order among themselves.

I should like to add one other piece of information about the Special Constable (established upon the basis of numerous personal observations). Severe alcoholism, that in the summer months can cause serious problems, becomes, in the nine long winter months a problem of greater magnitude. It can be the direct cause of death through freezing after falling unnoticed into the snow. In the late hours of the night or early morning, people who have been drinking in some home other than their own will start for their home. In this condition they sometimes fall, and in sub-zero temperatures, if they pass out, death comes within a few hours. This kind of death occurred during my period of fieldwork.

The Special Constable, of his own volition (for it does not fall within his appointed duties) spends many hours during these late hours driving his ski-doo in and out of areas between houses, along paths little travelled, and similar places where one might have fallen unnoticed while drunk. The number of lives he saves in this way have probably never been counted, nor probably never will be. I know, however, that in this purely personal responsibility assumed by the Special Constable, many lives are yearly saved in Nain.

The Angakok, "Shaman": This individual sets health standards informally through his behaviour. That is, his way of life is seen by the majority of the Inuit-Settler and Inuit to epitomize traditional Inuit life, i.e., in terms of diet, strength, endurance, response to sickness, and so on. Whether he had the authority to enforce these standards (or used it) could not be determined, but the possibility of his doing so should not be overlooked; I found it extremely significant that everyone informed me "he does not practice anymore."

V. SUMMARY

In addition to the other variables that have been shown to effect the socio-economic orientation of each social group, I would like to stress the importance of the period of time spent by each group in the community. It is through the total functionally-related behavioural system that cultural concepts are optimally reinforced. From a total of 650 people living in Nain, over half of that number do not occupy their homes between three and four months of the year. Dispersal of much of the population through the year produces unequal exposure to "acculturative" forces.

The following table shows Nain's yearly population dispersal by group:

TABLE II: Class Participation in Subsistence Activities

Social Group	Total Persons	Year-round in Nain	Subsistence Activities away from Nain
White	30	30	0
Settler	70	40	30
Inuit-Settler	250	200	50
Inuit	300	0	300
	650	270	380

A. The Two Principals of the "negotiating collectivity"

Of all the foregoing participants in the "negotiating collectivity" only two -- the IGA Nurse and the akiterijuq -- were actually experts in the field of healing. The roles of these women require a more comprehensive examination than other members of the group for purposes of coming to grips with the dynamics of the "negotiating collectivity." There were great differences in the ways in which each woman worked to achieve her objectives, both in dealing first-hand with health and disease, and in arbitrating with others in the collectivity:

The IGA Nurse: This individual -- an English-trained Midwife -- came to Labrador when a young woman. She served as a nurse in a Settler community in Southern Labrador prior to being stationed in Nain in 1951. She had learned the harsh realities of life that prevail in that part of the world, but knew little of the ways of the Inuit. She opened the station with limited funds and no other medical staff with training in the tradition of western medicine. Her first assistant at the station was the akiterijuq, her identity and function in the community unknown to the nurse, and with her assistance the nurse undertook the task of treating and educating the community in the ways of western medicine.

The IGA Nurse has always worked with the sanction of the provincial government and the IGA structure. She worked openly, could command extensive cooperation from hospital personnel, teachers, missionaries, RCMP, DNLA Manager, DNLA Fishplant Manager, and the like in Nain. She could, through radio contact, consult highly trained medical personnel in hospital facilities located in Southern Labrador and Newfoundland. She could call for the emergency service of air transportation for removal of patients, or for delivery of medical supplies.

Even with such extensive powers, she was frequently caught in a position where what she deemed necessary for appropriate community health care was in conflict with the Inuit-Settler/Inuit population. More importantly, her decisions were, at times, in conflict with the interests of Settlers and Whites as well. Consequently, she has often been in a position of having to act virtually alone and without support -- her legal and medical support hundreds of miles to the south -- against many, and sometimes all of the community.

The IGA Nurse went into semi-retirement the year I left the field, assuming the role of "Visiting Nurse." Two young western-trained nurses now relieve the nurse of the continual responsibility of delivering health care. I had the occasion to discuss the potential of her new role with the nurse shortly before leaving the field. She felt that for the first time she could devote her attention to the problems that were at the bottom of specific disorders existing in each family. In this way, she hoped that better health care could perhaps be brought to the people of Nain and was optimistic that her new role would be one step in that direction.

The Akiterijuq, "Native Healer": The akiterijuq, originally from the Hopedale Area, had been the daughter of a healer and, by age fourteen, had begun to assist her father in the healing arts of the traditional Inuit. Later, upon moving to Nain, she became the principle healer of that village.

Before the opening of the nursing station, there was no permanently stationed practitioner of western medicine in Nain. Missionaries had served as guides in matters of health and referred serious conditions to IGA hospitals following their (IGA's) establishment in the 1890's. Most missionaries received rudimentary medical training (first-aid) before taking up posts in various parts of the world, but to my knowledge only one Moravian missionary serving in Labrador has been a professionally trained medical doctor.

Consequently, native healers have always cared for the ongoing needs of the population; medical care from missionaries and IGA personnel were simply additional resources upon which to draw. So, for twenty-five years or more, the present akiterijuq delivered the basic health care to the native population. The extent of her activities in those years preceding 1951 included the delivery of babies, chiropractic-like services, the general treatment of wounds, organic disorders, and mental disorders that, among Inuit, include pragmatic as well as supernatural/spiritual principles.

The akiterijuq, as mentioned, assisted the nurse for a period of eleven years (1951-1962), and in this way learned the concepts and techniques associated with western medicine. It is to be inferred from discussion with the akiterijuq and numerous individuals from among the native population, that it was because of the presence of the akiterijuq in the nursing station in those early years that they were persuaded, so to speak, to utilize its services. In the majority of instances, such treatment was foreign to their experience and in many cases in conflict with their cognition of what constituted appropriate medical treatment.

Upon resignation from the station, the akiterijuq, who had retained her curer role thoughout, adjusted her services so as to omit those now "legally" within the jurisdiction of the nursing station. Basically, this meant she no longer delivered babies, nor took care of the full range of health problems as she had previously done.

An important new aspect of the akiterijuq's work is that she became (in view of the primary position given the IGA station legitimately) the first diagnostician to whom most Inuit-Settlers and Inuit will turn in cases of illness since she was no longer the only diagnostician. Applying the knowledge obtained from her exposure to both systems of medicine, the healer will undertake treatment of conditions seen to respond best to traditional techniques, or, in the majority of cases refers the patient to the nursing station. Her sense of responsibility is so keen in this capacity as first diagnostician, that if she discovers a patient does not go to the station, she will contact the nurse by phone and tell her that a particular person seems to be sick and that it might be a good idea to send the jeep for them. (There are three motor vehicles in Nain, two trucks and a jeep; the jeep is used by various people of authority for a variety of reasons; transporting seriously ill people to the hospital is one of them).

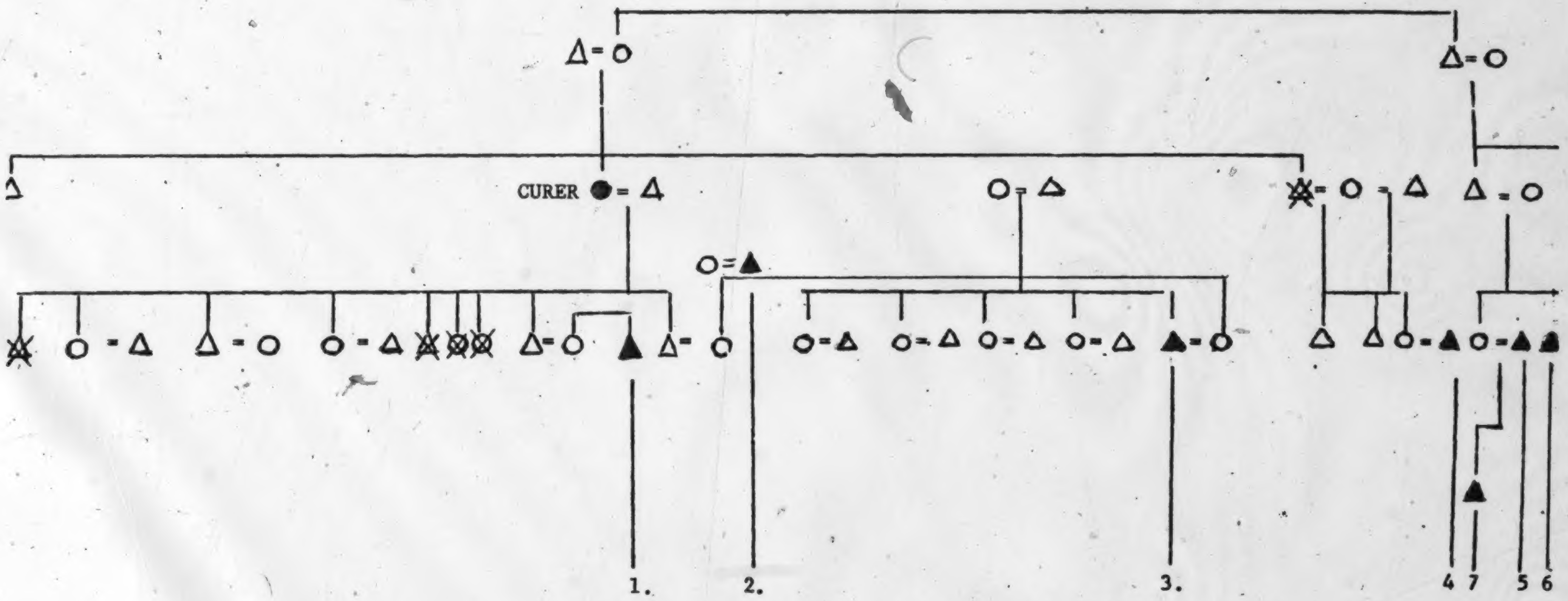
Since 1951 the healer has worked without "legal" sanction as defined by Canadian law, IGA definition, and Moravian view (presumably her choice). But, she has worked with the sanction of the 550 (smaller until ca. 1959) or so members of the native population. In an isolated village populated predominantly by people of the same cultural heritage, such sanction has been sufficient to ensure the continuance of her practice, albeit a practice restricted to "underground" tactics. Although Settlers, in most cases, do not utilize her services nor share the Inuit concepts of healing, affinal and consanguinal ties act to prevent their revealing the system's existence and bringing it to an end.

While the IGA Nurse's power came from legal and institutionalized authority invested in her by the dominant social group, the Whites, the akiterijuq's power has derived from kinship affiliation, traditional sanction of the healer's position within the social organization, and through having at her disposal kinds of treatment that are consistent with the cognitive system that operates for most of the population in the domain of health.

The precise relationships existing between the akiterijuq and other members of the "negotiating collectivity" are shown on the following page. Many other significant affiliations exist between her and members of the community, but only those holding roles of power in the community are examined here.

By means that have been briefly outlined on the preceding pages, and numerous others, the akiterijuq was seen to be the most powerful single individual in the "negotiating collectivity" with reference to health. She has acted as arbiter for change in traditional medical techniques in some areas, but has perpetuated the traditional system of medicine in other areas.

TABLE III: KINSHIP AFFILIATIONS OF CURER WITH ROLES OF AUTHORITY



1. Former "head" of Community Council = SoWiBro
2. Former "Chief" of Church Elders = SoWiFa
3. Present "Chief" of Church Elders = SiSo
4. Present "Head" of Community Council= BrDaHu
5. Caretaker of the Dead = MoBrSoDaHu
6. RCMP Special Constable = MoBrSoDaHu
7. Representative of Inuit Tapirisat = MoBrSoDaSo

B. Goals, Means and Attitudes of Each Social Group

When social or technological practices that have originated in ecological settings other than an Arctic environment are introduced into an Arctic setting, irreversible trends are set into motion. Such trends often result in damage to both the land and its inhabitants.

Changes of two major dimensions were introduced by the Moravians. One was the introduction of exploitive techniques to harvest natural resources; the other, the introduction of a class system. Subarctic and Arctic environments are optimally utilized technologically through harvesting resources at optimal times of the year and the natural balance best maintained through means other than commercial exploitation. Sociologically, such environments are best utilized through egalitarian, but cooperative, efforts that ensures the survival of all. Differentiation that comes with a class system fragments the unity that is essential to sharing equally the responsibilities that allow access to commodities required by all in this environment.

In order to illustrate this point, the particular goals of each social group in Nain, the means, or "social work," each group uses to achieve those goals, and the attitude of each group in relation to other social groups is given consideration on the following pages:

"WHITE"	(Goal):	The goal of this group, stated simply, is to manipulate the other three social groups in Nain.
	(Means):	Whites deal with powerful individuals in each social group, i.e., the "negotiating collectivity," rather than take issues to the population at large.

	(Attitude):	Whites see themselves as superior to each group. Settlers are seen as potentially equal. Inuit-Settlers are seen to have undergone a partial merger toward the kind of individual acceptable to Whites in Nain, and Inuit, or "Huskies," as they are referred to by Whites, are seen to be the most stupid of all who live in Nain.
"SETTLERS"	(Goal):	This groups' goal is to be on equal terms with Whites, having equal power as well as equal economic benefits.
	(Means):	Their special means of achieving this goal is to develop an independant economic base, which leaves them relatively free from government intervention, but also allows them to live in a manner similar to that of the White community.
	(Attitude):	They are worried about their "White" status. They see Inuit as "dogs," but although they feel superior to Inuit-Settlers, this is difficult to handle in most instances, since Inuit-Settlers are also "relatives."
"INUIT-SETTLERS"	(Goal):	This group fights retrenchment and seeks power at the community level.
	(Means):	They deal with Whites on White terms and in this sense are more flexible and adept than many Settlers, especially in their efforts to come by information that effects the village's future (back-stage techniques).
	(Attitude):	Inuit-Settlers see Inuit as "hicks," but there is a perverse pride in knowing they are not changed as they have been by contact. Inuit-Settlers see Settlers as weak, but are useful to manipulate.
"INUIT"	(Goal):	The primary goal of the Inuit is to fight retrenchment and to hold on to their autonomy as long as possible.
	(Means):	This is done among Inuit through undercover negotiation, secretive means of acquiring important information (Special Constable and Shaman), but they also have had sufficient

contact to use techniques used by Whites to gain their ends, i.e., strategic manipulation.

(Attitude): Inuit see themselves as superior to all other groups in Nain because they are "of the land" and are of "pure" blood, not having mixed with Whites to the extent that Inuit-Settlers have.

The "negotiating collectivity" is a result of the complex social structure of Nain which is itself a historical product.

Each member of the "negotiating collectivity" has numerous personal considerations that influence his stance in each case where matters of health must be resolved. Many individuals of this group, therefore, act not from the perspective of how best to meet threats to human life and welfare, but from the perspective of how their own -- or that of their social group -- position will be enhanced.

COMMUNITY RESPONSE TO SELECTED EPISODES OF ILLNESS

CHAPTER FIVE

I. INTRODUCTION

Eight case studies are presented in this chapter, each chosen for its ability to demonstrate some of the many contingencies that bear upon health in Nain and determine the particular coping strategy that is pursued in specific kinds of illnesses. Community response depends upon the action or nonaction of individual members of the "negotiating collectivity." When nonaction is the course followed by member(s) of the collectivity, it will be due to 1) circumstances which prevent action, e.g., the member(s) does not have sufficient power access to take action, or, resources are simply not available to them, 2) nonaction by choice, e.g., the case of Juliana. Whether action or nonaction constitutes the position taken by members of the collectivity, the community's response to member(s)' action will be determined by what they know each member's scope of power to be.

I am interested not in attributing psychological motive to members of the "negotiating collectivity," but in how their actions are interpreted by the community. Just as I have, for the most part, confined case studies to those that were unsuccessfully negotiated, I have refrained from justifying or placing blame on individuals comprising the collectivity. This allows for focus upon the system itself and why it is increasingly strained to cope with the health circumstances in Nain.

When health matters reached the community level, there was the greatest numerical participation by members of the collectivity; it is also at this level the most interest is generated among individual members of the collectivity. Decisions made at the community level, involving representatives of every social group, are implemented and become standard practice by Canadian law, IGA ordinance, DNLA policy, or Community Council ruling. It is at this level that decisions relating to health, and perceived by Inuit-Settler/Inuit as important, may be changed to those preferred by EuroCanadian administrators. Those Inuit-Settler and Inuit members of the collectivity who participate in arbitration at this level realize that it is here they must head off such changes, or relinquish elements they see as essential to the Inuit-Settler/Inuit way-of-life.

Case studies of physical illness deal only with examples taken from the Inuit-Settler/Inuit segment of the community. This is because Whites and Settlers received different health treatment than did the Inuit-Settler/Inuit (see Chapter I). Chapter Six will explore, from the perspective of the western medical facilities in Labrador, further reasons why Inuit-Settler/Inuit receive a different kind of health care than do Whites or Settlers in Nain.

Whites in Nain use only the nursing station facilities and are flown to a southern Canadian hospital of their choice (as opposed to having to use the IGA hospitals) at the first indication that more professional attention than is available through the nursing station is required. Settlers do not have quite the same access to outside medical care as Whites, since they, like the Inuit-Settler/Inuit, are normally sent to IGA hospitals. The similarity in treatment of White and Settler lies in their using only western medical facilities, and for relatively minor disorders if they so desire. Such resources are simply not available to the native population. This is not really the fault of the nursing station, but can be attributed to the fact that the utilization of the native system of medicine by Inuit-Settler/Inuit has resulted in little pressure being placed upon IGA officials to provide equal health care.

Thus, the full range of western medical health care is a limited resource in Nain. When resources are limited, then someone has to decide who will get those resources. In Nain, the "negotiating collectivity" decides.

When the objective of members of the native population was to receive the same access to western medical facilities as Whites and Settlers (as opposed to their objective being to receive treatment within the native system of medicine), the following alternatives were available:

1. First, if someone in the White power structure placed sufficient value on a specific Inuit-Settler/Inuit, the same health care privileges were extended to that person as to a White or Settler, e.g., the head clerk of the DNLA Store was essential to the smooth operation of the store. Further, he was the organist and central figure to the musical functions of the Moravian church in Nain. When this individual experienced the slightest physical impairment he was quickly flown south to an IGA hospital. He was the only Inuit-Settler or Inuit of whom it was said he was in the hospital because he "needed a rest."

2. The second option available to an Inuit-Settler/Inuit who needed special attention was for the native members of the collectivity to exert pressure upon the White members of the collectivity to provide such needs, e.g., see the case of Ellius.

3. Thirdly, was the option that nothing happened at all. If the native population's estimate of an individual suffering from serious conditions of health was nagative, Whites did not intervene. In cases of this type there was no appeal from community judgment (see the case of Juliana).

Health problems that relate to individuals usually do not receive the same degree of attention that is to be found in illness affecting the entire community. Both the kind and extent of medical attention an individual will receive depend upon several factors: 1) Social group affiliation is the first determinant, following that, the patient's standing within his social group will have a direct bearing upon the extent to which his condition will be given consideration, i.e., superficial treatment, or in-depth diagnosis, treatment, and follow-up. A member of the collectivity may intercede on a patient's behalf, who in himself is without sufficient prestige, and in this way make available to a patient services he would otherwise be obliged to wait for, or, receive only minimal treatment. (The severity and urgency of a physical condition can, and do override considerations of status in most instances.) 2) Generation is of significance in personal physical illness. Nurses at the IGA station responded more quickly and were continually on the alert for illness among the children, while physical illness among the mature population was responded to in a more matter-of-fact manner. This does not imply that adequate medical services were not available (although "adequate" is defined depending upon whether one is Inuit-Settler/Inuit or White/Settler) to all age segments of the community; it means that preplanning and preventive medicine involving physical malfunctions was not equally observable among all age groups.

This differential in services on a generational basis cannot be attributed entirely to the lack of interest on the part of the IGA facility's personnel; the fact of the matter was, older members of the Inuit-Settler/Inuit population resisted overtures on the part of the IGA to intervene in physical health problems unless the patient decided to seek help from the nursing station, and they rarely did so. This attitude may be traced to continued reliance on the native system of medicine. People, many as young as their mid-twenties, still place their trust in traditional remedies and concepts about the proper response to illness, preferring the akiterijuq's services to those of the IGA nursing station.

Mental illness in the community receives as great, or even greater attention than community-wide illness from Inuit-Settler/Inuit. It is necessary to examine mental illness separately from that of community illness (where illness is openly negotiated), and physical illness (which is not structually important to the native social system). Mental illness is the arena in which the actual work of ensuring that behaviour among the native population is maintained along lines that will continue their existence in a viable culture. This category of illness was the core of the Inuit-Settler/Inuit social system; it was the means by which judgment, regulation, and permission for change of its members originated. Consequently, the handling of mental illness is not open, not arbitrated with White or Settler members of the collectivity, but confined to members of the Inuit-Settler/Inuit community. Its members are still the important individuals of the collectivity, but their sphere of action is closed to Settler or White members. In some ways, the IGA Nurse may be aware of this native medical system, but if she is, by tacit agreement, perhaps subconscious on her part, she does not attempt to intervene in any of its activities.

Lastly, not only is action of the "negotiating collectivity" vital to any solution in health matters in Nain, but inaction is just as crucial to what will be done in any given situation. Members of all the social groups of the community look to members of the collectivity for cues in what they should do individually -- what position they should take when a matter is brought before the council for a vote -- and what position they should take in individual cases of either physical or mental illness. If members of the collectivity do not act, no one else is likely to do so.

II. ILLNESS AT THE COMMUNITY LEVEL

There is a commonality existing between two case histories that comprise this section, i.e., venereal disease and the hepatitis epidemic. Health is the primary consideration in each instance. The third example, that of the oil shortage, is only marginally related to health. My reason for including it is that it demonstrates the general power structure of Nain. Moreover, it has serious implications with regard to preventive medicine; these implications were of great importance to both the IGA Nurse and the akiterijuq prior to, and following, the crisis. All three cases had one significant factor in common; the solutions were arrived at according to economic, political, or religious priorities. Accounts of previous community-wide health crises effecting the community recounted to me by informants indicated that similar priorities were almost always given precedence over the health of the native population.

A. Venereal Disease

This case is significant, not as a single event that temporarily caused community concern during the term of my fieldwork, but because it is a continuing crisis with rather set positions taken by members of the "negotiating collectivity." To my knowledge, no member of the collectivity deviated from his position on the issue during my period of fieldwork, nor has continuing correspondence indicated that the situation has changed since that time.

Venereal disease is among the most serious health problems in Nain. Nineteen per cent of the population experienced gonorrhoea during the period of 1971-1972. Unknown until after contact with the western world, the disease is still poorly understood by the native population.

The specific configuration of "actors" that operate in the handling of this health problem is that the DNIA Fishplant Manager is the principal protagonist of one position, and the IGA Nurse the principal protagonist of the other. In this instance, the alliance formed to support the Fishplant Manager's position is a conscious one, that which has arisen to support the IGA Nurse's position functions independently, and even unconsciously of the other's effort in most cases.

1. (Alliance headed by the Fishplant Manager)

The official position taken with regard to venereal disease within this alliance originates from the personal position and evaluation of the situation taken by the Fishplant Manager. He is supported by the DNIA Manager, who because of his close economic ties and shared objectives with the Fishplant Manager, finds it advantageous to follow the

Fishplant Manager's lead in this instance. Through the DNLA Manager's influence, the third member of the alliance, the "Former" Chief Elder, an Inuit-Settler, has been convinced that Nain's economy will be jeopardized if the continual lay-off of persons thought by the nurse to have venereal disease is permitted. He, in turn, passes along this interpretation to the Inuit-Settlers and Inuit in the community coming under his influence. It was difficult to determine with any degree of accuracy how many persons acted upon the "Former" Chief Elder's influence in this case, but I would think it substantial.

I came to know of the alliance's existence upon the occasion of the DNLA Fishplant Manager's first visit to me early in my fieldwork. During our discussion, I mentioned a forthcoming appointment with the IGA Nurse.

Although he was normally dispassionate, he launched into a "character assassination" of the IGA Nurse. He included detailed accounts of how the nurse was not only incompetent, but worse, purposely mistreated the native population. He maintained that the nurse kept a "list" -- one that every white person in Nain had access to, but no native person even knew of its existence -- which bore the names of every individual "thought" to have venereal disease; he said the nurse was not really interested in whether one had gonorrhoea or not, she was satisfied to simply think one had the disease. To this end she pried into the sexual lives of people coming to the station for other purposes, and if she was successful in eliciting information that gave her reason to suspect they had gonorrhoea, she then pressured them until she had obtained the names of all with whom they had had sexual relations in the recent past.

These names were added to her list as well.

On a weekly basis, the nurse sent this list to the DNLA Fishplant Manager with the request that he "lay off" all those whose names appeared on the list until they had completed treatment. How, he asked, could he possibly run the fishplant without people to work the lines? It never failed, he assured me, that just as someone was getting good at their job, the nurse got it into her head they had gonorrhoea. He avoided direct confrontation with her, but defied her authority, stressing her incompetence whenever possible, to all who would listen.

At length, he said that in spite of her meddling, he had his ways of handling her. He either ignored her requests to "lay off" an individual altogether, or intervened before an employee went to the nursing station, advising against this course of action. He felt qualified to determine whether one had gonorrhoea or not on the basis of courses in biology and chemistry and the life, that had been part of his own training. If someone obviously had gonorrhoea, he added, he did refer them to the nursing station.

He argued his case as though he was the last bastion between the native people and the brutalities of both the missionaries and the nurse. Yet, behind this self-righteous indignation, commercial quotas had to be met, and people were necessary to meet those quotas. Because of his rationalization of his position, many people in Nain did not receive treatment for gonorrhoea, or, when they did, it was a more serious condition because of having delayed treatment.

2. (Alliance headed by the IGA Nurse)

During my first interview with the IGA Nurse, I brought up the topic of venereal disease in the community, without revealing that I had prior knowledge of the matter. As with the Fishplant Manager, the subject brought about an immediate change in the nurse's demeanor. Unlike his, which had been one of rage and vindictiveness, the nurse showed only deep concern and at times, hopelessness. She saw the large percentage of persons having gonorrhoea to be a result of the populations' ignorance of the disease, their delay in coming to the station for treatment, their "lax" sexual mores, and their general indifferent to disease of any kind.

She remarked that the whole issue was taken so lightly by the native population that even those who were constant repeaters would come into the station for treatment, and upon her inquiry about the nature of their visit, would laughingly inform her, "Well, I've got that thing again!"

Asked why she had not requested films to be sent to Nain for the purpose of educating the Inuit-Settler/Inuit to the nature of venereal disease, she responded that she, and the Moravians, "...didn't want to spoil their innocence" by exposing them to such films. I then suggested that literature bearing on the subject could be distributed among the population. She said "they" wouldn't read it.

She reported that she tried to control the spread of gonorrhoea through keeping people with active cases away from the fishplant where they might contaminate others, or the product itself, but added that she did not always receive the best cooperation from the Fishplant Manager.

The remaining members of the alliance, most of them unknown to the nurse as being part of her preventive team, supported the nurse's primary objective -- to prevent the spread of venereal disease in Nain -- through an assortment of means and for reasons that often differed from those which motivated the IGA Nurse. These individuals were the akiterijuq, the Moravian Minister, and two young men who sold condoms in Nain illegally and undercover.

The akiterijuq, being cognizant of the fact that many among the native population refused to report symptoms of gonorrhoea to the nursing station because of fear of losing their jobs and fear of the treatment itself, kept a close watch on those she suspected might have become infected. Through her grapevine she knew who did have gonorrhoea, and knew, in many instances, who was engaging in sex with whom at any given time. If those falling under her suspicion did not report to the nursing station within a reasonable period of time, the akiterijuq paid them an informal visit, and usually succeeded in motivating the victim to go to the station for treatment. When this failed, the akiterijuq called the nurse on the phone and said she had heard that the individual had contacted gonorrhoea.

Activities pursued by the Moravian Minister were a one-man operation with two objectives in mind: one, through his almost daily questioning of Nain's female teenage population, he hoped to detect either pregnancy or venereal disease, and two, keep constant vigilance upon the "lax" sexual practices of the younger generation. Many young girls are sent by him to the nurse with the instructions that they are to be examined by her for pregnancy, venereal disease, or both. In this way, presumably, some new cases of gonorrhoea are detected.

Two enterprising young men in Nain have established an agreement with a druggist in the south of Labrador whereby he sends prophalactics to them through the mail. They, in turn, sell these condoms at a profit to those who are both "in the know" and able to afford them. The extent to which condoms were used for the purpose of avoiding infection from gonorrhoea could not be determined, but I would think it minimal. Most Inuit-Settler/Inuit in Nain cannot afford the high cost of condoms. Moreover, the sale of prophylactics in Nain is forbidden by the Church.

One young man put the situation quite well one day when I asked him what he thought caused gonorrhoea (meaning the agent by which one became infected). He replied, "People here drink a lot of brew, you know, and when they get loaded forget who has v.d., and who don't have v.d., and just go to bed with who they're with...sometimes its the wrong person."

3. (Discussion)

In Nain, where two major cultural groups exist and the "negotiating collectivity" is comprised of individuals from four social subsets, behavioural violations by members of the community at large are numerous in the eyes of members of the collectivity. In each case study, breaching episodes, i.e., failure to behave in the expected manner or respond in an anticipated fashion, stop continued negotiation with other members of the collectivity and, by extension, the whole community.

Inadequate handling of venereal disease can be attributed to the fact that conflicts within the power structure of Nain override community level health problems of specific kinds. Community health problems are all post-contact. Saliency (see Chapter One) of the health domain remains in traditional areas -- contrast mental conditions among Inuit-Settlers/Inuit where their system still operates and health of the community where individual physical problems are the only issue -- but becomes becomes subject to other considerations outside these areas.

Evidence for this conclusion is based upon the results of the DNLA Fishplant Manager's taking a position in opposition to the older White establishments within the community. That opposition polarized individuals within the dominant culture as well as increasing polarization between members of the dominant and subject cultures. Although such polarization led to more negotiating room for the subject society vis-a-vis Whites, it resulted in less adequate health care.

In this instance, the two principles with expertise in matters of health, returned the matter to the domain of health. Their tactic failed to result in successful resolution of the problem, because within the community structure of Nain, health carries less weight than economics. Consequently, each principle lost in her attempt to fight the issue from within the domain of health. Neither would have experienced failure to deal with a community health problem had it not effected the work force of the Fishplant, e.g., a measles epidemic among children in the community with respect to the IGA Nurse, or an unusual rise in cases of dislocation of joints among males of the native population with respect to the akiterijuq.

The community at large was led to further dissension in this instance because members of each social group knows the scope of power of each member of the collectivity. Inaction is a product of variables beyond the control of any of the principles and the community (with the exception of certain key members of the collectivity, e.g., akiterijuq, "Former" Chief Elder, and the more astute members of the Inuit-Settler/Inuit constiuency) recognizes the impasse.

Because of the structural complexity of Nain, no one social group can fully control the outcome of situations of crisis proportions. Nonetheless, individual members of the collectivity, as well as people from the community in general, feel that they have an input to the resolution of community-level crises. They cannot change the system, but feel they can vie for strategic victories within it. The community power structure regulates health, but if others did not make an input, community structure would disintegrate.

The following tables illustrate breaching episodes in the handling of venereal disease. The notion of breaching involves several things. One, the purpose of the person who breaches may consciously be the effect(s) of the breach, or, in other instances people do things they fail to realize will be a breach. Secondly, the whole point of a breach is the interpretation given that action by others; hence, I will note which segment(s) of the community perceives specific actions as a breach. Each breaching episode will also be evaluated for its impact upon the community from the analyst's perspective. Breaches that have been isolated for examination do not necessarily constitute the entirety of such breaches for any single case. Those included for examination are those I personally observed, or, were reported by a substantial number of informants.

TABLE IV: Breaches involved in Venereal Disease

BREACHES	Fishpl. Manager	Nurse	Minister	Akiterijuq	Condom Sales.
1. List containing names of V.D. patients available to Whites only.		X			
2. Fishplant Manager undermining Nurse's authority.	X				
3. Fishplant Manager discouraging early medical treatment for V.D.	X				
4. Nurse & Moravians blocking educational material bearing on V.D.		X	X		
5. Minister's interrogation of teenage girls regarding sexual behaviour.			X		
6. Minister's unauthorized referral of teenage girls to nursing station.		X	X		
7. Akiterijuq's reporting unreported cases of V.D. to nursing station.				X	
8. Violating church regulations regarding sales of condoms in Nain.					X
9. Placed other priorities, e.g., economic or religious, above health.	X	X	X		

Breach #	Perception of Breach by Actors					Perception of Breach by Others			
	FPM	NURSE	MINIS.	AKIT.	COND.	WHT	SET	I-S	I
1.	-	+	+	-	-	=	=	-	-
2.	+	-	-	-	=	=	-	-	-
3.	+	-	-	-	-	+	-	-	-
4.	-	+	+	-	-	+	=	0	0
5.	-	+	+	-	-	=	-	-	-
6.	-	+	+	-	-	0	-	-	-
7.	0	0	0	+	-	=	=	-	-
8.	+	-	-	+	+	+	-	-	-
9.	+	+	+	-	=	+	=	-	-

Key to above Table:

+ = appropriate
- = inappropriate
= = indifferent
0 = unaware

Key to Abbreviations:

FPM = Fishplant Manager
MINIS = Moravian Minister
AKIT = Akiterijuq
COND = Condom Salesmen
WHT = White
SET = Settler
I-S = Inuit/Settler
I = Inuit

	Analyst's Evaluation of Breaches					
	Dominant Culture: Effective Short-term	Dominant Culture: Ineffective Long-range	Subject Culture: Effective Short-term	Subject Culture: Ineffective Long-range	Reinforces traditional value system	Contributes to Community Dissension
1	X	X				X
2	X	X				X
3	X	X		X		X
4	X	X		X		X
5	X	X		X	X	X
6	X	X			X	X
7			X			X
8			X			X
9	X	X		X	X	X

B. Hepatitis Epidemic

Unlike the community health problem created by the high rate of venereal disease that constituted an on-going health problem, the significance of this epidemic lies in the fact that it was a health problem effecting the entire community. As such, effective response required immediate and unified mobilization of the community's human resources which was not forthcoming.

1. (Alliances in the Epidemic)

Factionalization was more pronounced in the handling of the hepatitis epidemic and those alliances that were formed were both fragile and transient in nature. The IGA Nurse was the sole protagonist for a plan to control the spread of hepatitis, and, in opposition to her stood almost all the remaining population. In attempting to explain this lack of cooperation with the nurse in something so serious as a community-wide epidemic, I suggest two major factors: one, the leading protagonist was a woman, which was in conflict with the concept existing among Euro-Canadian administrators (all male) that men should take over in an emergency, whatever its nature. The fact that she was a female was not a factor in the Inuit-Settler/Inuit populations failure to cooperate. Second, opposition to her directives from the Inuit-Settler/Inuit segment of the community was based upon the fact that they did not understand the reasons for her directives - they were in almost every instance in contradiction to the native system of medicine -- nor did they comprehend the biophysiological nature of hepatitis. The EuroCanadian males did not dare question her expertise and legal sanction in assuming the role of leadership, yet they would not yield to her the necessary cooperation demanded of them. With the missionary on leave in Europe, and the RCMP's powers not extending to partisan matters, there were no White males to mediate between the nurse and the community. Normally, in the nature of her profession the nurse would not be placed in the role of leadership and some of these same individuals were her allies, in most instances.

With the exception of the akiterijuq and a few individuals that she was able to influence at a later stage of the epidemic, none of the Inuit-Settler/Inuit members of the "negotiating collectivity" acted to support the nurse's directives because they were in opposition to concepts of treatment of illness held by these members.

2. (Dynamics of the Epidemic)

The first cases of hepatitis appeared in early December 1971, but caused little alarm. Only when the number of people infected began to increase at an alarming rate did people become aware that there was an epidemic in their midst. Inuit-Settler/Inuit understand the meaning of an epidemic in particular instances, e.g., influenza, measles, but the frequency with which hepatitis has occurred in Nain, to date, has been minimal. Once the IGA Nurse publically acknowledged the epidemic, she proceeded to determine the source of contamination, and with this knowledge to work out a general plan to bring the epidemic under control.

She identified the source of contamination by following a hunch and walked up to a hill above the site of the dam that was under construction. Knowing the habits of workmen in that they relieved themselves near the site of work, she speculated she might find human feces about the area; what she did not expect to find was the extremely large quantities of feces. She realized then, that during periods of warmer temperatures, this matter would be washed, by snow slippage and melting, down the hill and into the Nain Brook, contaminating the community water supply.

She then went to the DNLA Manager, briefed him on the situation, and asked that he discharge a man with a bulldozer to push soil, snow and waste materials further up the hill to a point where it would not, with rising temperatures, be carried back into the brook. She met with decided reluctance on the part of the DNLA Manager. She persisted until he finally sent a man to remove the material from above the water supply.

Not being content to leave the handling of the emergency within the jurisdiction of the IGA Nurse, the DNLA Manager told her he would put a stop to this "nonsense" by sending men to pour liquid bleach into all the contaminated water holes, and by doing so, would "purify" the water so the villagers could continue to use the water. She, knowing the extent of the contamination, tried to point out that such measures would be useless, and additionally informed him that Inuit-Settler/Inuit hated the smell and taste of bleach, and would not go near anything that had been mixed with it. She asked instead that he hire men to go by ski-doo to distant points from Nain and bring back barrels of uncontaminated water for the village's use. He refused to do this, and so their negotiation ended.

Not heeding the nurse's warning about the Inuit-Settler/Inuit dislike for bleach, the DNLA Manager promptly added some to the contaminated water holes. By the next morning the entire community was astir, for not only were their water holes "poisoned" they were now ruined by having had bleach poured into them. Inuit-Settler and Inuit men began digging new water holes in the Nain Brook, not understanding that all the water in that brook was contaminated.

Several days of chaos reigned. During that time the akiterijuq attempted to explain the danger of using water from the Nain Brook to some members of the collectivity and others within her influence in the village. This was not too successful, for the "Former" Chief Elder, always quick to follow the lead of the DNLA Manager and the new "Head" of the Town Council, sided with the DNLA Store Manager. Only the Chief Elder of the Church, and a few members of the town council acted upon the akiterijuq's advice and attempted to convince people that they must travel to places far from Nain in order to get "clean" water. Settlers, generally, took the advice of the IGA Nurse and traveled the necessary distance to obtain uncontaminated water. This practice, at last, was followed by most of the community. This was a great hardship for the women who had to travel long distances by foot and pull loaded twenty gallon barrels of water back to Nain. Some men, although this was women's work, made the trips by ski-doo, pulling the heavy barrels on their komotik behind them.

The IGA Nurse outlined a simple list of procedures to be followed by all in the village who became infected with hepatitis. These were:

1. Water must be obtained from sources distant from Nain.
2. Those becoming infected with hepatitis should go to bed, cease to visit among people, keep their dishes separate from those used by the rest of the family, drink plenty of fluids, take the pills that would be dispensed from the nursing station, and eliminate

fat from their diet until well.

Many of the native population, although aware that people were getting sick and "turning yellow," were not overly concerned, even when one among their own household got sick. One reason so little attention was given to the epidemic was that the first cases appeared just before Christmas and the last, not until late January. This meant that the nurse's directives interferred with the usual Christmas preparations -- a time of great activity and excitement among Nain inhabitants.

The akiterijuq became engaged in detecting undiagnosed cases of hepatitis, for she had entry into people's homes. The nurse was restricted to the station where they were busy administering treatment. Upon discovering signs of hepatitis, the akiterijuq would instruct the individual to go to the nursing station. Sometime they would follow her advice, but just as likely they would not. Men, as is typical of Inuit-Settler/Inuit men under any conditions, were more likely to refuse to go to the nursing station. Under these circumstances the actual number of those infected with hepatitis will never be accurately ascertained.

Many of the Inuit-Settler/Inuit saw the nurse's directives as a joke. The following question was put to me by a young woman from whom the nurse had requested a urine sample: "Did you know Jupp is collecting pee now? Must be she can sell it in Goose Bay, you think?" On another occasion the nurse asked some teenagers to bring her samples of the contaminated water so she could analyze it. They told me Jupp's "crazy" request was silly, and asked me "What's Jupp want to look at old wormy water for? She ought to be taking care of sick people!"

The most disturbing part of the nurse's directives was related to diet. Inuit-Settler/Inuit see meat and fat to be essential to good health. Thus, the nurse's warning against eating fat while ill was seen as a diabolical scheme to make people even sicker. In many cases, people increased their fat consumption to make them stronger and enable them to fight off the sickness better.

Near the end of December I was visited by the akiterijuq, who asked me, "Have you looked in the mirror today?" I said "No." She then ordered me to "get it and go look in the light of the window." I thought my tiredness was due to the hard work associated with Christmas preparations and hauling water. But the akiterijuq said "You're yellow, and I think you better go see the nurse, I think you could have hepatitis." I postponed my visit to the following morning, not really believing I could have become infected.

The next morning I awoke aching badly and decided I should go to the station just to make certain I was all right. I did not mention the akiterijuq had already diagnosed me as having hepatitis. Following her examination, the nurse said "You've got it too," and began pouring pills into a bottle. "Get to bed, don't do anything for a week, lay off all fats, get lots of fluids, take these twice a day, and let me know if you get worse." I asked how, if I were to stay in bed, would I be fed and do the other necessities for survival in Nain? She said I could hire someone to do those things for me. I realized, of course, that this option did not exist for the Inuit-Settler/Inuit. I then asked wouldn't I contaminate whoever that might be? Drearily, she responded "Everyone in Nain has already been contaminated, it's simply a matter of who will and who will not come down with it, so get someone to help you for you won't be exposing them any more than they will naturally be exposed."

My research assistant brought his fifteen-year-old sister to me to take over the housework. I spent a considerable period of time explaining to her that she might come down with hepatitis; although she listened politely to all that I said, she just asked "What do you want me to do?" Later, my assistant said it had hurt his sister that I had not understood that she had come to help me being fully aware of the danger. Social priorities are more important than health. I knew this, but my concern for the young girl had temporarily caused me to forget. One of the first, and most important lessons I learned when living with the curer, was that social priorities take precedence even when a member of one's own family might be exposed to disease. The lesson to which I refer occurred one day when several children were playing in the house of the curer with the curer's adopted daughter (in fact, her granddaughter). Normally serene, and courteous to children when in her home, on this day the curer appeared to be nervous. At length the children left, and the curer said to me "I'm glad he's gone, it makes me so worried when he plays with Linda." Not understanding, I asked which child made her worried, and she identified the little boy. Not comprehending still, I asked was he a "naughty" child. "No, he's got t.b." I wanted to know why she simply did not tell the boy he couldn't play with Linda. Looking at me as though I had asked a most unintelligent question, she said "I don't want to hurt his feelings."

When I neared recovery, the IGA Nurse visited me one evening and I asked her to what she attributed the epidemic. She began by telling me it could have been predicted and prevented. The Department of Public Works in Newfoundland had sent people to Nain a couple of years before to create a plan to upgrade living conditions in the community. She had told them that their plans for modernization were useless without a wholesome water supply, coupled with a sewage system, and available to every home. The representatives, all men, took exception to her straightforward criticism and ignored her recommendations.

We then discussed other reasons why the epidemic had been difficult to bring under control. Infectious hepatitis, she said, could be transmitted orally and the food habits of the native population were conducive to transmission by this means, i.e., the use of dippers in homes that all used to drink water from, the handling of food without washing one's hands, and redistribution of meat between households (even though it is no longer done on the traditional basis, this continues in a less formal way). There was a reluctance on the part of Inuit-Settler/Inuit women, she said, to use much soap in their dishwater, and they did not rinse dishes at all, nor did they use disinfectant on dishes even when illness was present in the home. Dish towels were used until extremely dirty, and dish rags were used to clean anything from ski-doo greese off the floor to a child's dirty hands. Added to these practices, were the social attitudes that operated regardless of sickness, whereby people fondled children and children known to be sick were allowed to play with other children.

I than asked her why she had not sent a sample of the water to St. John's for analysis, in order to force better cooperation from the DNLA Manager, or even enlist the aid of health authorities in Newfoundland.

She said that a viable sample would have to arrive within eleven hours in a laboratory. The available air transportation would take from five to seven days. I asked could not this be seen as an emergency that warranted a special plane dispatched to Nain for the sole purpose of getting a sample back to St. John's for analysis? She did not reply to this question.

3. (Discussion)

The epidemic required full cooperation among all members of the "negotiating collectivity," yet received the least effort from its members than in any other health problem that I observed while in Nain. This can be attributed to the fact that all segments of the community -- and individuals within each segment -- were unprepared for the epidemic and relied upon basic models of action in an emergency within each social group.

Since the IGA Nurse was professionally prepared as a matter of her experience and training, she alone could and did immediately respond with an effective plan. She further threatened the other members of the collectivity (except the akiterijuq) in presenting a plan when they had none. Inuit-Settler/Inuit members of the community were the major victems of the epidemic, but their concepts of illness did not give to the epidemic a status of seriousness. Only through the continued efforts of the akiterijuq to force partial compliance with the nurse's directives were most cases treated at all. Both the IGA staff and the akiterijuq knew that a multitude of health problems could develop as a result of having had hepatitis and were consequently deeply concerned. The Inuit-Settler/Inuit, not understanding this, made light of the episode and bore the immediate discomforts of having hepatitis without fear.

TABLE V: Breaches involved in Hepatitis Epidemic

BREACHES	DNLA Manager	IGA Nurse	Akiterijuq
1. IGA Nurse's lack of diplomacy when conveying to DNLA Mgr. role of leadership was hers		X	
2. IGA Nurse's issuing directives that were in direct conflict with native system of medicine.		X	
3. DNLA Manager's failure to supply adequate toilet facilities for workmen, creating circumstances re epidemic	X		
4. DNLA Manager's refusal to relinquish role of leadership to IGA Nurse.	X		
5. DNLA Manager acting in ways not empowered by his role, i.e., making decisions re epidemic, e.g.; bleach in water	X		
6. DNLA Manager's refusal to accommodate IGA Nurse in concrete matters re handling of epidemic.	X		
7. DNLA Manager's efforts to undermine nurse's directives to the native population.	X		
8. Akiterijuq's persistence that native population follow IGA directives instead of native system's.			X

Breach #	Perception of Breach by Actors			Perception of Breach by Others			
	DNLA Manager	NURSE	AKITERIJUQ	WHITE	SETTLER	I-S	INUIT
1.	-	+	+	-	+	+	+
2.	0	+	-	+	-	-	-
3.	=	-	-	=	=	=	=
4.	+	-	-	+	-	-	-
5.	+	-	-	+	-	-	-
6.	+	-	-	+	-	-	-
7.	+	-	-	+	-	-	-
8.	0	0	+	0	=	-	-

Key to above Table:

+ = appropriate
- = inappropriate
= = indifferent
0 = unaware

Key to Abbreviations:

DNLA Manager = Division Northern Labrador Affairs Manager
Nurse = International Grenfell Association Nurse
Akiterijuq = Native Healer
I-S = Inuit-Settler

Analyst's Evaluation of the Breaches						
	Dominant Culture: Effective Short-term	Dominant Culture: Ineffect- Long-range	Subject Culture: Effective Short-term	Subject Culture: Ineffect- Long-range	Reinforced traditional value system	Contributed to Community Dissension
1	X	X	X	X		X
2		X		X	X	X
3	X	X	X	X		
4		X		X		X
5		X		X	X	X
6		X		X	X	X
7	X	X		X	X	X
8			X			X

C. The Oil Shortage

Although only peripherally a health problem, no community health problem that occurred while I was in Nain created the disquiet and anguish that accompanied the oil shortage. Its arbiters were numerous and its handling complex. My own part in it represents my most concerted effort as an "honorary" member of the "negotiating collectivity" to alter the course of events in Nain. I had realized at a relatively early stage of fieldwork that I was, by virtue of my role and reasons for being in Nain, automatically a member of the collectivity and one with more negotiating room because no social group ties restricted my activities or effected my ability to observe dispassionately. Further, I had wider access to the community's institutions and without the usual responsibilities and allegiances that accompany such access. Up to that time I had concentrated on my primary objective to carry out health research in the community. Only in this crisis did I take steps to ensure a resolution.

There were "worldly" matters that bore upon the handling of the oil shortage which I, no less than the native population, were unaware of during most of the crisis; in brief, due to the upcoming election for the position of Premier of Newfoundland, of which Labrador is a voting district, knowledge of a crisis among the "Eskimos" was kept from the general Newfoundland public. Inefficient handling of such matters by the party in office could have become an effective political weapon.

1. (Alliance formation during the Oil Shortage)

Those of the "negotiating collectivity" whose alliance functioned to keep the shortage from becoming known had a difficult task in January, February, and March of 1972. Out of the "negotiating collectivity" emerged a tightly knit alliance consisting of the DNLA Manager, the DNLA Fishplant Manager, the "Former" Chief Elder, the present Chief Elder, the "Head" of the Community Council, and the owner of the privately operated grocery store in Nain. Their own positions (economically and politically) were aligned to the political party in power. Mismanagement of the oil shortage would affect their own jobs.

2. (Dynamics of the oil shortage)

My knowledge of the situation first came from a Settler, a man I later discovered was the primary promoter in Nain on behalf of the contending political candidate. As the Settler undoubtedly anticipated, I immediately took steps to determine whether there was a shortage and began to question various Inuit-Settler/Inuit friends. No one with whom I spoke seemed to think a shortage existed. So, I resumed more pressing research activities.

Within a week, however, rumors began to circulate about the possibility of an oil shortage. Some Inuit-Settler and Inuit men had made an actual "nose" count of the remaining barrels of oil and realized that there was insufficient oil remaining to carry the village through the winter. The next rumor was that the DNLA Manager had told one of his staff members that if a shortage did occur, the DNLA stores, its staff, the hospital, school, teacher's residence, church buildings, and the RCMP's residence would get priority to the oil that was left. These rumors, true or not, inflamed the Inuit-Settler/Inuit population. Within the week, the oil shortage had become the sole topic of conversation.

New rumors began to circulate, among them, that Settlers -- not already having their own supply of stove oil -- were buying large quantities of oil from the government store and transporting it by night to remote areas in the country where they buried it in the snow.

Near the end of February I went to the government store to buy a drum of oil. After the clerk checked with the DNLA Manager, he returned and told me to send someone for it and I could have it. I arranged for someone to go after the oil, but he returned shortly saying that the oil I could have was buried under solid ice. Normally it would have been the last oil to be sold in the month before the coastal boats brought the new oil supply to Nain for the coming year.

I asked the DNLA Manager point blank how many more barrels of oil could I expect to purchase from the government store. He replied, "none." He then suggested that the owner of the privately owned store in Nain might sell some of his own oil that he had saved up. I left and went to the other store and asked to see the owner. He told me that he might be able to get some if I were willing to pay a few extra dollars, because he had to hire someone to go get it. I agreed and obtained the oil.

A day or so later a meeting between the DNLA Manager, the Fishplant Manager, and the other members of the alliance was held. They announced that construction on the mission school's new wing would stop for the winter so that oil now used to keep the few carpenters warm while working on the building could be redirected to the people of Nain. For a few days oil was actually sold across the government store counter, but then this too, abruptly ceased. At this point, only Whites, Settlers, and a few privileged Inuit-Settlers had stove oil. Most Inuit-Settlers without woodburning stoves were beginning to move in with relatives or friends who did have such stoves, but some Inuit-Settlers and Inuit who had no one with whom to move in with began to use any kind of fuel they could purchase from the government store, i.e., white gas, kerosene and gasoline. These mixtures were used in the family's stoves without knowledge of its various properties; as long as it burned no questions were asked.

On the night of March 7th an explosion virtually destroyed the fancy, and yet uncompleted, art center under construction within the Moravian church complex (the center was to be used to display native crafts for sale to tourists who come to Nain during the summer months aboard the coastal vessels). Some said the explosion had been set off deliberately as a result of anger created by the oil shortage. It is worth note here that anger is not considered appropriate to one who is mentally healthy, but the community's range of discriminate attributes allows for anger if it is supportive of the community's welfare (see page 35 and case histories in the remainder of this chapter). Others thought the explosion had occurred because the Moravians had stored oil there for their own use, and that something had just "gone wrong."

Two days later, on the morning of March 9th, the home of Paulus Nukasak exploded at 5:00 a.m. He, like many others in Nain, had been mixing all kinds of oils and gases to keep his stove going so that his large family could remain in their home. The husband and teenage son escaped with serious injuries, but the mother and her five children were burned to death. Fire is dreaded in Nain at any time of the year, but during the winter no water with which to fight fires by means of a bucket-brigade is available.

There is a related tragedy which bears upon the way in which Inuit-Settler/Inuit respond to death and also their means of dealing with the mental trauma that can result from such tragedies:

> A few hours after the fire I saw a young couple pulling their heavilyladen komotik from across the bay toward Nain. I asked my assistant why they were leaving the husband's parents' home -- not knowing the kinship ties existing between the family that had died in the fire and the family living across the bay -- he said "Old Noah and his wife are about to lose their minds with sorrow. Jane and her husband will move in with them and soon Jane's baby will be born, then the old grandparents will want to live again." The parents of the woman who had burned to death, and grandparents to the children who died with her, had adopted one of these children when she was a baby. Although they lived across the road from one another, the adopted infant had never spent the night in her biological parents' home until the night of the fire.

By now I was running low on my one drum of "black market" oil and knew I must reach a decision about my future in Nain before it gave out altogether. There were several alternatives open to me: I could ask to move back with the akiterijuq, or to board with some other family. But none of these alternatives seemed to be a solution to the problems that beset Nain. I decided to contact the institute that funded me, let them know my position and ask their advice in the matter.

I placed a radio call to the financial administrator of the ISER in St. John's, Newfoundland from a nearby Settler's home. I might add that radio sets are owned and operated by the DNLA Manager, the Mission, the Nursing Station, the RCMP, and the privately owned store's manager. It was a common custom for all to listen to every call that was placed outside Nain, and knew that all would be listening to the call between the ISER representative and myself.

Upon reaching the ISER representative, I quickly told him of the oil shortage and the barrel of "black market" oil I had purchased, but added that I would not buy another from that source since the native population was not extended the same privilege. In fact, I told him I thought I should leave the field. Additionally, I told him of the disaster of the family that had died because they were not among the elite entitled to "safe" oil in Nain, and that I could not really continue research under these conditions. He informed me he had no knowledge of an oil shortage in Nain, and said he would contact the Minister of Labrador immediately and would call back later in the day.

Within an hour or two he called back, telling me that the Minister of Labrador had called the DNLA Manager in Nain and asked was there a shortage of oil. The DNLA Manager had denied it explicitly. Upon hearing this, I concluded our talk by telling the ISER representative that "There is an oil shortage. The DNLA Manager is lying, and I'm leaving on the next plane."

An unexpected call came from the ISER representative late in the same afternoon. He had talked once more with the Minister of Labrador about the matter. The Minister wanted him to assure me that I would not suffer from lack of oil, and that I should not leave the field. I replied "tell the Minister that unless he can make the same promise to every single Eskimo family in Nain, then I am not interested in his promises." I did not hear anything more from the ISER representative nor the Minister of Labrador, and left, as planned, in the company of my research assistant, on March 15, 1972.

The village survived, for once it became known publically that the oil supply was almost exhausted in Nain cavalcades of ski-doos originating in southern Labrador villages tranported barrels of oil overland to Nain.

3. (Discussion)

With respect to health, consequences of the oil shortage were not of a dramatic nature; an increased number of respiratory illnesses were reported, and the akiterijuq was pressed into service to deal with the results of stress ensuing from the emotion-laden interaction between individuals and social groups throughout the crisis. Disorientation among the Inuit-Settler/Inuit members of the "negotiating collectivity," who had not been party to the DNLA Manager's alliance, were the foci of more serious damage. Inuit-Settler/Inuit members of the collectivity saw, as a result of their uninvolvement and helplessness during the crisis, themselves devalued as adequate representatives for their constituencies. Further retrenchment appeared to be the only option open to them as a means to maintain some control over the social regulation of the community and cultural identity.

TABLE VI: Breaches involved in the Oil Shortage

BREACHES	DN Mgr	DN FpM	HD Com	FOR CfE	PRS CfE	PVT Str	W	S	I-S	I
1. Failure to calculate sufficient oil for community's needs when advance ordering	X									
2. Decision to keep shortage secret at village and provincial levels.	X	X	X	X	X	X				
3. Selecting men whose careers hinged upon keeping shortage secret for alliance.	X	X								
4. Allocation of oil on basis of group membership/elitism, not need.	X	X	X	X	X	X				
5. Accelerating oil shortage by buying in bulk due to economic power.							X	X		
6. Inflammables sold to native people without warning of inherent danger if mixed.	X					X				
7. Selling oil on "black market" for economic gain.						X				
8. Selling church oil supply without authorization.	X					X				
9. Possible deliberate destruction of arts/crafts center.									X	X

BREACH #	Perception of Breach by Actors						Perception of Breach by Others			
	DN Mgr	DN FpM	HD Com	FOR CfE	PRS CfE	PVT Str	W	S	I-S	I
1.	-	-	-	-	-	-	-	-	-	-
2.	+	+	+	+	+	+	0	0	0	0
3.	+	+	+	+	+	+	0	0	0	0
4.	+	+	+	+	-	+	+	+	-	-
5.	+	+	+	+	-	+	+	+	-	-
6.	=	=	=	=	-	=	=	-	-	-
7.	+	+	+	+	-	+	+	+	-	-
8.	+	+	+	+	-	+	+	+	-	-
9.	-	-	-	-	=	-	-	=	+	+

Key to above Table:
+ = appropriate
- = inappropriate
= = indifferent
0 = unaware

Key to Abbreviations:
DN Mgr = DNLA Manager
DN FpM = Fishplant Mgr.
HD Com = Head Community Council
FOR CfE= Former Chief Elder
PRS CfE= Present Chief Elder
PVT Str=Private Store Mgr.
W =White
S =Settler
I-S =Inuit-Set.
I =Inuit

Analyst's Evaluation of Breaches						
	Dominant Culture: Effective Short-term	Dominant Culture: Ineffect-Long-range	Subject Culture: Effective Short-term	Subject Culture: Ineffect-Long-range	Reinforces traditional value system	Contributes to Community Dissension
1.	X	X		X	X	X
2.	X	X		X	X	X
3.	X	X				X
4.	X	X		X	X	X
5.	X	X		X	X	X
6.	X	X	X	X	X	X
7.	X	X				X
8.	X	X				X
9.			X		X	X

D. SUMMARY OF COMMUNITY LEVEL ILLNESS

None of the preceding cases illustrate how specific health problems would have been handled if they had reached the level of arbitration within the Community Council, or become subject to intervention by provincial or federal agencies. Only community illness episodes that were dealt with by the IGA, DNLA, and various alliances from among the "negotiating collectivity" were included in my examples. This was not accidental, but appears to be a pattern that operates in Nain when health problems arise that effect the entire community. This pattern prevents serious health problems from coming to the attention of agencies outside Nain, which could result in standardized procedures being implemented to be followed in future crises. Negotiation by the White members of the collectivity is equally successful in preventing regulation from within the community by arbitrating problems informally rather than present such matters to the locally constituted body of the Community Council.

At this point I would like to review the effectiveness of negotiation in each of the preceding cases; I shall be interested in isolating the benefits and losses in each health episode for specific segments of the community.

Criteria used to evaluate such benefits or losses will be based upon whether the social group designated benefitted in ways that resulted in their health not being seriously effected, or, if to the contrary, the health of that social group suffered extensive damage.

A second criterion will also be used in evaluating the effectiveness of the negotiation of each case, that being, whether side benefits or losses not directly involving physical or mental trauma, were received by any segment of the community.

Figure 4: Assessment of Community Level Negotiation

Social Group	Illness	Success	Partial Success	Failure
Inuit-Settler/Inuit	Venereal		x	
	Hepatitis		x	
	Oil Shortage			x
Settler	Venereal	x		
	Hepatitis	x		
	Oil Shortage	x		
White	Venereal	x		x
	Hepatitis	x		x
	Oil Shortage	x		x

INUIT-SETTLER/INUIT

Inuit-Settler/Inuit experienced partial success in dealing with venereal disease due to their having become aware of the fact that condoms help in preventing the spread of the disease. With this knowledge it is potentially possible that they will devise some means whereby they may procure such devices for themselves.

Partial success may also be assigned to the overall toll upon the Inuit-Settler/Inuit population's health during the hepatitis epidemic. This may be attributed to the substantial numbers of the native population that the *akiterijuq* was able to convince to abide by the IGA Nurse's directives. That she, and other Inuit-Settler/Inuit individuals of importance, were able to further convince most of the native population to go to distant points for their water supply can be seen as a partial success in the negotiation that took place during the epidemic.

Inuit-Settler/Inuit suffered the greatest loss by the oil shortage of any group in Nain. Only those few Inuit-Settlers who received preferential treatment did not suffer hardship.

SETTLERS

Settlers fared better than any segment of the community in all cases cited. Because they have economic resources, they can and do make use of prophalactics to protect themselves from contacting venereal disease.

Settlers are also cognizant of the fact that specific measures must be taken to prevent transmission of disease through contact. Hygenic practices followed in most Settler homes resemble those of middle-class EuroCanadians and result in an environment not conducive to the spread of disease.

Settlers, being economically in a position to purchase oil in large quantities, were able to remain relatively free from the problems created by the oil shortage.

WHITES

A double standard will be used to evaluate the success or failure of each case with respect to the White population of Nain. One standard will ask, "did the White population personally suffer from illness or deprivation in any episode under consideration?" The second standard will ask the question, "did the White administrators of Nain successfully fulfill their professional responsibilities to the people of Nain so that the three community-wide health problems were successfully handled?"

Whites did not experience difficulties personally as a result of venereal disease being prevalent in the community. If sexual relations were engaged in between White males and Inuit-Settler/Inuit females, either safeguards through the use of prophalactics or the use of the nurse's list to determine whether a woman was free from the disease were available to them.

To my knowledge I was the only White in the community who experienced hepatitis. The same measures used by Settlers to prevent contamination were employed by members of the White community to ensure against contacting hepatitis.

The oil shortage did not personally effect any White in Nain.

Now, the second standard by which one may evaluate the White administrators' success or failure in dealing with each health problem will be examined.

As stated, the issue of venereal disease in Nain has resulted in a stand-off whereby neither alliance will change its tactics so that the disease may be brought under control. This is a failure of the White administrators to interact effectively with regard to this particular health problem.

White administrators were incapable of extending cooperation and assistance to the IGA Nurse during the hepatitis epidemic. This resulted in serious consequences for the native population's health. This too, can be seen as a total failure among White administrators to meet a community health crisis.

Political priorities and the personal fear of losing their positions resulted in the creation of a secretive alliance whose objectives overrode considerations of health. Consequently, community negotiation which could have contributed to the handling of the oil shortage in a more effective manner, was prevented. This too can be assessed as a complete failure of White administrators to meet a crisis that effected the health and welfare of Nain's inhabitants.

III. PHYSICAL ILLNESS

Interaction of members of the "negotiating collectivity" in situations involving individual cases of physical illness or "mental conditions" was quite distinct from that found to operate with respect to community level health problems. Alliances were rarely formed in order to arbitrate on behalf of an individual's physical health. Rather, one member might choose to act. Clearly, it was the akiterijuq's decision to intervene that was most important, and more than any other member of the collectivity, it was she who usually initiated action on behalf of those with a physical health problem.

Cases involving individual physical illness have been included because individual illness in Nain is pandemic. For, at this level, neither community or outside health agencies, nor the native system of medicine are sufficient to meet the needs of individuals. Reasons for this are numerous; some have to do with cognitive dissonance between the two systems (see Chapter Six); others have to do with the sheer numbers of individuals requiring medical attention in a community that is understaffed in medical personnel (this applies to the native system of medicine as well as that of the IGA medical facility in Nain).

The most significant reason that physical illness at the individual level receives little attention, however, is that the energies of the two systems of medicine in Nain are concentrated in a struggle for dominance. The native medical system invests much of its attention in directing behaviour in the process of retrenchment. Individual "mental conditions" receive greater attention than is generally found in instances of physical illness because it involves values. Representatives of western medicine in Nain (and Labrador generally) similarly spend considerable time and energy in the attempt to change Inuit-Settler/Inuit concepts about health. Health care is a limited resource, consequently, the individual suffering from a physical illness holds a low priority in the total picture of health care in Nain.

The following case studies illustrate the range of responses that were possible with regard to community support, or lack of it, in situations involving physical illness.

A. Ellius

Ellius was not a native of Nain, nor was he amongst those Inuit relocated to Nain from norther Labrador. In the early 30's he and his family had moved to Nain from an Inuit community in southern Labrador. At the time of fieldwork Ellius was about 56 years of age and most of his life had been spent in the Nain area.

Prior to 1971 Ellius had spent his time away from Nain much of the time following a way of life that was traditional in orientation. He would occasionally return to Nain to work as a carpenter or electrician when he felt inclined to do so (skills he had acquired doing construction work at Goose Bay during World War II), but essentially refrained from specific commitment to a predictable mode of earning his livelihood.

Ellius' status in the community was a mixed one. He was respected for his skills, his ability to support a large family, yet he was seen as overly independent. He held an important role in the community's traditional life which accrued to him certain spiritual qualities. This role, in a sense, sanctioned his more than ordinary individualistic behaviour. He managed to remain uncommited to any specific mode of life mainly through his great capacity for work and his political respectability.

His general health had always been excellent, but after moving to Nain on a more permanent basis, he, along with his wife, began to indulge heavily in the consumption of homebrew. Nonetheless, he maintained a high degree of physical vitality and functioned well in his various work assignments. The hard pace he set for himself in any job he was given, coupled with heavy drinking, was said by informants to have contributed to his subsequent illness.

In the fall of 1971 Ellius fell from the roof beams of the house on which he was working when he suffered a stroke. He was flown to an IGA hospital in the south of Labrador where he learned that he was entirely paralyzed in the right side of his body, and had lost all speech.

According to the doctors who appraised him of his condition, he could not hope for much improvement.

Shortly after returning home from the hospital, he lurched against a boiling kettle of water, overturning the kettle, and received third degree burns over the paralyzed portion of his body. Following this incident, although still physicall limited, he was much improved, and regained some use of his limbs so that he was able to walk about Nain. There was no doubt in his mind that the burn had "shocked" his body awake.

Particular individuals of the collectivity approached the DNLA Store Manager on behalf of Ellius, asking that he receive disability and that his family receive government subsidy. This was done, but some friction ensued because the DNLA Manager went through the normal channels to obtain the requested aid. Those who had intervened on Ellius' behalf felt the usual procedures should have been by-passed. This was not done. Instead, the DNLA Manager allowed Ellius to charge those items he needed until the government aid came through. By the time his benefits did come through, needless to say, Ellius was deeply in debt to the store.

During that period relatives and friends tried to help the family with food and other necessities, but were unable to fully meet the requirements for the family's needs. Ellius told me that people were no longer able to be like they were in the "old times." Some of it, he said, was due to their own changed way of looking at things, but he knew too that some of it was that they couldn't help themselves, let alone help others.

Because his illness had, in a very short period of time, rendered him useless for productive labor for the remainder of his life, he was forced to reevaluate his position in his society. Normally, he would not have been looked upon as being old at 56, especially in view of the fact he had been a vigorous man. Now, he willed himself to the role of an old man, and turned to homebrew as a daily necessity to cope with his new status.

None of these facts went unnoticed by family, friends, or members of the collectivity. However, in discussing Ellius' situation, they saw no way in which they could change it; too many people needed help. Local EuroCanadians were also aware of the critical situation in which Ellius' stroke had placed both him and his family, but other than taking the steps to obtain disability payments and government subsidy, they saw nothing further they could do to alleviate the problem.

TABLE VII: Breaches involved in Ellius Case

BREACHES	ELLIUS	DNLA MANAGER
1. Ellius remained uncommitted to any specific social group in Nain throughout his life.	X	
2. Ellius successfully ignored major economic trends promoted by the White culture throughout his life.	X	
3. DNLA Manager refused the collectivity members' request to by-pass usual channels to secure government subsidy for Ellius.		X
4. The DNLA Manager's requirement that Ellius justify each charge to him was demeaning in view of Ellius' traditional role in the community.		X
5. By following normal procedures for obtaining government subsidy, it meant that Ellius would forever be in debt to the DNLA Store.		X

BRCH #	Perception of Breach by Actors		Perception of Breach by Others			
	Ellius	DNLA Manager	White	Settler	I-S	Inuit
1	+	-	-	=	±	+
2	+	-	-	=	+	+
3	-	+	+	-	-	-
4	-	+	+	-	-	-
5	-	+	=	-	-	-

Analyst's Evaluation of Breaches						
	Dominant Culture: Effective Short-term	Dominant Culture: Ineffect-Long-term	Subject Culture: Effective Short-term	Subject Culture: Ineffect-Long-range	Reinforces traditional value system	Contribute to Community Dissension
1		X	X	X	X	X
2		X	X		X	X
3	X	X		X		X
4	X	X		X	X	X
5	X	X		X		X

Key to foregoing Tables:

+ = appropriate
- = inappropriate
= = indifferent
0 = unaware

Key to Abbreviation:

I-S = Inuit-Settler

B. Simiak

Simiak was one of the children whose parents were forced to relocate from their home in Nutak, a traditional village north of Nain in the late 1950's. They had first gone to Makkovik, a community south of Nain, and it was there that Simiak was born in 1957. At birth he was "sickly." When he was eight years of age his family moved to Nain. At that point he began to experience a variety of difficulties, for the family's stability was by now thoroughly shattered; both parents had become alcoholics and it was during this period after moving to Nain that the mother stabbed the father and had to spend some time in prison. Psychological difficulties Simiak experienced are apparent in that he began to steal, and to "waste" his parents' homebrew purposely (translated this means he threw their homebrew out); concommitant with both kinds of behaviour he began to receive regular and severe beatings from his parents. Physical problems that manifested themselves between the ages of 8 and 10 years included chicken pox, periodic attacks of influenza, bronchitis, chest pains, and vomiting. From that time in his life to the present he has always had numerous kallak, "scabs."

At age ten he was stricken with tuberculosis and was taken to the IGA hospital in St. Anthony's, Newfoundland for treatment. He remained there for six months and remembered almost all of that experience. Most of all he recalled his loneliness, for he did not understand at that age why he was taken from his parents, nor where they were. Only once did the IGA arrange for his mother to fly to St. Anthony's to visit him during his hospitalization. He was so happy to see her, but when she left again, he did not know what had happened to her, and spent many miserable days believing she was dead. Inuit, even children of that age, have no fear of dying but there is a terrible fear of the dead, especially the spirits of the dead that linger about cemetaries. Thus, while confined to the hospital Simiak lived in daily dread of the time when he would be summoned for an "outing" to the nearby graveyard.

When at last he was considered sufficiently well to return to his home, he was flown back to Nain. I asked how he felt on the day that he arrived back home. Smiling, he said, "I was so proud when I got back." He began school shortly afterward, but remained under the nurse's care for several months.

The most serious injury Simiak suffered in his life occurred on July 5, 1971, only six weeks prior to my arrival in Nain. While working on the mission boat, the Lake Hebron, the ship's winch swung from its intended course and struck him in the head causing critical injuries.

The boy was taken to the IGA station at once, for several people had witnessed the accident. The IGA Nurse recalled how when she first saw him his mouth was mangled, his head caved insward in several places, his face lacerated by deep cuts, his tongue severed in pieces, teeth lying loose in his mouth and his jaw was broken. She first removed the teeth, following that, she worked blind -- because of the profusion of blood in his mouth -- to stitch the severed tongue together. Then, examining his head she found splinters of bone embedded in the brain -- which was exposed at places -- and although fearful of attempting to extract the bone fragments, she felt that to leave them could mean instant death. After removing these bone fragments she stitched up the worst of the head wounds. It was several days before she dared have him flown to St. Anthony's hospital where doctors with more sophisticated techniques and equipment could continue to work on him. While at St. Anthony's a plate was inserted in one area of the skull, but when he is considered to have completely recovered from the incident, he will undergo surgery in St. Anthony's once again to repair injuries to the skull incurred from the accident. He remained in the hospital not quite five weeks; his recovery was so rapid that it soon became impossible to keep him in bed, so he was sent home. I met him almost six weeks to the day after his accident; he had just returned from a swim in the "boy's water hole" on the day I met him.

I at first thought him to be lying about the date on which he had suffered the injury. Later his claim was verified by the IGA Nurse who looked up the date in her log. She dismissed my disbelief at his quick recovery with the remark "they're tough here, and healthier than they have a right to be." This young man became my close friend and helped me whenever I needed an extra hand.

His mother deserted the family in the early part of 1972 after a severe beating from her husband and went to Makkovik to live. One night he came to do work for me in the capacity of informant and I noticed that although it was easily -30°F. outside, he wore only thin rubber fishing boots used in Nain during the summer months, but never in the winter. I knew his feet must be cold, but not until he propped them on a chair did I realize they were also wet, for numerous holes were worn in the bottoms of the boots. I told him to pull off his boots and I would dry his socks while we were taping. I put cardboard inside his rubber fishing boots to make a solid sole, and told him he should save the money that I paid him for working as an informant to buy a pair of ski-doo boots. He agreed to do so.

In Nain, news, even to one's socks having been dried and cardboard insoles put into boots, travelled fast. By noon of the following day, Simiak came into the shack grinning broadly and extending his feet for me to see his "new" boots. For some reason, my attention to his socks and boots the previous evening had resulted in his father buying him a second-hand pair of leather boots to wear which had sturdy soles and plenty of wear left in them; and, the nursing station had given him three new pair of beautiful all-wool socks. I could not determine what had happened from talking to the boy, so forgot about it. This was not the first time I had noticed that if someone from the "negotiating collectivity" did a kindness of that sort to a member of a family not his own, it had the effect of bringing about instant changes for the better in that person's life. In spite of the toughness of life in Nain, intervention by members of the collectivity can potentially result in change for the better at both the private and public level.

Most people in Nain liked Simiak. He was a pleasant guest to have in one's house, and a willing worker when a job was underway, whether it was his responsibility or not. Simiak never asked for food or money without offering to first work for whatever he requested of people. Women saved bits of food for him, the hospital nurse saved old clothes for him and even new ones she had access to on occasion, and she never tired of giving comfort and reassurance when he suffered from some after-effect of his summer's injury; various people of the "negotiating collectivity" interceded on his behalf with his father in an attempt to prevent the father from beating Simiak when the man was drunk, for it was known to all that one wrongly placed blow would kill the boy. Men of importance in the community lent him their guns and gave him ammunition and took him along as their companion when hunting or fishing.

I learned from talking to various members of the "negotiating collectivity" and people generally, that they recognized his strength and potential. Inuit-Settler and Inuit saw him in terms of traditional stories of boys who, although orphaned, poor, or abused, grew up to be the best hunters and the wisest of men.

TABLE VIII: Breaches involved in Simiak's Case

BREACHES	Simiak	Simiak's Parents	IGA Hosp.	Neg. Coll.
1. During Simiak's pre-teen years he stole, lied, and destroyed his parents' property, i.e., homebrew.	X			
2. Members of the collectivity failed to take sufficient interest in his abnormal behaviour at that time, nor to intervene at any level.				X
3. Simiak's parents violated traditional concepts regarding appropriate punishment for youthful misbehaviour, e.g., he was subjected to beatings.		X		
4. IGA Hospital (not local Nurse) breaches cannot be treated individually, but all are subsumed under failure to understand concepts of native medical system			X	
5. As the family continued to deteriorate, Simiak begged the necessities for survival, e.g., food, clothing.	X			
6. Following Simiak's head injury, members of the collectivity were unable to cope with his family to ensure his protection.				X

BRCH #	Perception of Breach by Actors				Perception of Breach by Others			
	Simiak	Simiaks Parents	IGA Hosp.	Neg. Coll.	White	Settler	I-S	Inuit
1	+	-	0	-	0	=	-	-
2	0	=	0	=	0	=	=	=
3	-	=	0	-	0	=	-	-
4	-	-	+	-	+	=	-	-
5	+	=	0	+	-	+	+	+
6	-	=	=	-	=	-	-	-

Analyst's Evaluation of Breaches						
	Dominant Culture: Effective Short-term	Dominant Culture: Ineffect- Long-range	Subject Culture: Effective Short-term	Subject Culture: Ineffect- Long-range	Reinforces traditional value system	Contributes to Community Dissension
1						X
2			X	X		
3						X
4	X	X		X	X	X
5			X	X	X	
6				X		X

Key to above Tables:

+ = appropriate
- = inappropriate
= = indifferent
0 = unaware

Key to Abbreviations:

IGA Hosp. = International Grenfell Hostal
Neg. Coll. = Negotiating Collectivity
I-S = Inuit-Settler

C. Juliana

This case study occupies a borderline position between physical illness and mental condition. In a larger perspective it concerns how illness is subject to still more important considerations than the mere presence of illness, whatever its nature. Juliana was a social outcast. She was perceived by the Inuit-Settler and Inuit community as having violated numerous codes of traditional behaviour, consequently, she was outside the consideration of both family and community whatever problem might befall her. A fact which makes her case all the more interesting is that she was the daughter of a very important member of the "negotiating collectivity." This fact resulted in two separate reasons why she had no recourse from the status of outcast. As a daughter of an important family, it was felt that she had a special responsibility to act in ways befitting a "true Inuit" (although they were Inuit-Settler by virtue of having been long-term Nain residents). Her position was made even more serious in that the member of the "negotiating collectivity" that was her parent had, because of his role, both to establish and enforce negative sanction against his daughter; no one else could by-pass this.

Until puberty, her life was in no way remarkable. She was well nourished, received the full nine years of Moravian schooling, and received better than average medical attention during that period of her life. In my dealing with her as an informant, I found her to be one of the most intelligent individuals in Nain.

The first serious physical condition to which she was subject occurred when she was thirteen years of age and became pregnant. The condition went undetected until she became seriously ill. It was her good fortune that at that time a medical doctor from a southern Labrador hospital was visiting in Nain. He diagnosed the girl to have a tubal pregnancy. She was flown to a hospital where an operation was performed to save her life. Theoretically, such pregnancies may be assumed to have occurred before, but it is possible that Juliana's was the first to be diagnosed and the condition made known to the population in general. The English translation that was given her condition by the doctor to the Inuit-Settler/Inuit community was that she had a "baby growing on her side." The native population still sees this to have unusual connotations.

Following that incident, she developed both a rheumatic heart and chronic asthma. Neither were brought under control during her teenage years and at the time of fieldwork Juliana suffered periodic ill-health from both conditions.

In her late teens she became pregnant out of wedlock once again and gave birth to a girl. The father of the child, a man a few years older than Juliana, claimed fatherhood and wanted to marry her. He was extremely well respected in the community, in fact he was seen to be a sort of hero as a result of an episode in which he had been instrumental in saving several people's lives. She refused to marry him and he became qivitok, "a hermit," and left Nain. Because of his having been so well respected, his condition was blamed on Juliana's refusal to marry him. By the time she was in her early twenties she was already seen as deviant in behaviour and in the physical conditions she experienced.

Shortly after the Northern Inuit were relocated to Nain, Juliana married one of the young men from amongst this group. The fact that she was from an important Inuit-Settler family with a high standing in the community where class lines were becoming tightly drawn combined with her previous rejection of a well-liked Inuit-Settler to bring her under still further negative sanction.

After marriage to this man, she gave birth to two more children. She had kept her first child from the man she had refused to marry. Her husband was unable to make a successful adjustment to relocation in Nain and became a constant offender of the law and spent much of his time in the St. John's prison in Newfoundland. Additionally, he developed physical problems during the first years of relocation to Nain that left him incapable of holding either a steady job in the village, or pursuing traditional activities effectively.

During their early married life the husband beat the child Juliana had had out of wedlock. Juliana's mother, upon finding this out, took the child from them and refused to let them have her back, even when they begged for the child. This embittered the community further toward Juliana.

Once again, Juliana became pregnant. When the infant was almost a year old, her husband committed another legal offence and was to be sent to prison. During a long drinking bout preceeding his departure, Juliana killed the baby by wrapping it tightly with several blankets, making it impossible for the infant to breathe. Infanticide is traditionally acceptable, but in this instance the infant was almost a year old, and that is not considered by Inuit-Settler/Inuit as infanticide. To kill a child of that age has always been murder.

Although the RCMP was called to the scene, it was difficult to establish by Canadian law whether it had been murder or an accident. Thus, Juliana was acquitted by Canadian law, but in the eyes of the native population she was now a murderer; the fact that she was not jailed had no bearing on the incident.

To demonstrate the manner in which members of the community responded to her severe physical and financial problems, I will discuss two episodes that occurred during the period of fieldwork.

1. Juliana had been working for me as an informant when one morning I arrived for an appointment to find her and her children in bed; she seriously ill with bronchitis (her husband was again in prison). I found that they had had neither heat in the house -- this was mid-winter well below zero temperatures prevailed -- nor had they had food for two days. No one had called on them during that time.

When I told the woman's parents, her mother called her daughter's husband's parents and told them Juliana needed some firewood. Feeling this was insufficient, I requested that she also call the nursing station and tell the IGA Nurse about her daughter's physical condition. This she did and soon a jeep arrived to take Juliana to the nursing station for penicilin and some other medication, promptly returning her to her home.

When I discovered she still was without food I purchased both food and other essentials and took them to her mother. Despite her status as an outcast in the community, Juliana personally was an extremely proud individual and I did not want to offend her. The mother said she would take the food to the girl's husband's parents and they could give it to her. When it was discovered that I had sent food to Juliana and intervened in other ways as well, I, for a period of a few weeks, was held in negative sanction and people refused to interact with me. This soon passed, however. My research assistant told me that people had decided I was a stranger and did not know any better.

Later, through questioning of numerous individuals and the IGA Nurse, I discovered that the nurse, although fully aware of the severe physical problems and deprivations to which Juliana was subject, did not intervene herself to a great extent on the woman's behalf because of the community's position. Invariably, Inuit-Settler or Inuit people with whom I talked would say "she brought it all on herself," and dismiss the matter.

Juliana received government subsidy, but would put most of the money into homebrew ingredients, or occasionally some piece of clothing for the children. In this way she was always without money. Without proper clothing, in a perpetual state of ill health, she did all the wooding for herself and her two children. She hauled all their water, chopped the wood, and did the heavy work that normally would have fallen to her husband. Her brothers and sisters, and parents as well, were all relatively financially secure, but did not give her assistance in any way.

2. A few weeks later I heard that Juliana was being "held" in the nursing station. I could not find out from anyone why. The nurse refused to discuss the matter. My research assistant was the only person who would talk to me about the situation, and did let me know that this was unusual procedure. No one ever stayed a long time in the nursing

station, he said. If they were that ill, they were sent out to a hospital.

He and I agreed that the nurse had finally taken affirmative action in order to protect Juliana from her own self-destruction and the village's refusal to assist the woman. The enforced stay in the nursing station allowed the nurse to ensure that she ate well, received treatment for her various ailments, but most importantly, to make certain she did not have access to alcohol.

Some of the villagers talked about what the IGA Nurse was doing, so my assistant told me, but did not confront the nurse. The only thing I finally was told by the nurse was that she was going to allow Juliana to spend one night with her husband who would soon be returning from prison, and then she was flying her out to the hospital for some long overdue medical attention.

Still puzzled about the nurse's actions, for I had long realized the nurse's priority had to be her relations with the Inuit-Settler/Inuit community, I looked back through my journals for clues. In doing this I found a note about a visit to Nain by a woman medical doctor from one of the IGA hospitals in the south. She had remained in the village only a few days, but her inquiries into specific cases and long talks with the IGA Nurse were common knowledge in the community. It was shortly after her departure that Juliana was confined to the nursing station. For the IGA Nurse, this was an opportunity to act without seeming responsible in the eyes of the community.

TABLE IX: Breaches involved in Juliana's Case

BREACHES	Juliana	IGA	Moravians
1. Juliana breached by having a bizarre pregnancy in her early teens.	X		
2. Juliana breached health expectations of young females by developing two unusual chronic health conditions.	X		
3. Juliana refused to marry an important man in the community by whom she had become pregnant again; he then became "qivitok," hermit.	X		
4. Juliana married a newly relocated northern Inuit seen to be beneath her family's status.	X		
5. She failed to prevent her new husband from mistreating the child fathered by man who had become "qivitok" hermit.	X		
6. Juliana's mother took that child from her by force and adopted the child as her own.	X		
7. Juliana killed another of her infants while drunk.	X		
8. The IGA doctor who created the English gloss for tubal pregnancy failed to consider the effect his label would have upon Juliana's life.		X	

TABLE IX: Continuation of Breaches

BREACHES	Juliana	IGA	Moravians
9. IGA Hospital and local nurse failed to recognize both chronic illnesses were related to her stigmatization.		X	
10. Local IGA Nurse failed to provide (until 1972) adequate health care for Juliana due to the community's concensus of Juliana's status.		X	
11. The Moravians perceived all of Juliana's actions as "sin" resulting from willful behaviour. As such, they did not intervene on her behalf.			X

Breach #	Perception of Breach by Actors			Perception of Breach by Others			
	Juliana	IGA	Moravians	White	Settler	I-S	Inuit
1.	0	=	-	-	=	-	-
2.	0	=	=	=	=	-	-
3.	+	0	-	=	-	-	-
4.	+	0	-	=	-	-	-
5.	-	0	-	=	=	-	-
6.	-	0	+	=	=	+	+
7.	-	0	-	-	-	-	-
8.	-	=	=	=	=	-	-
9.	-	=	-	=	=	-	-
10.	-	-	=	=	=	+	+
11.	-	0	+	+	=	=	=

Analyst's Evaluation of the Breaches

	Dominant Culture: Effective Short-term	Dominant Culture: Ineffect- Long-range	Subject Culture: Effective Short-term	Subject Culture: Ineffect- Long-range	Reinforced traditional value system	Contributed to Community Dissension
1				X		X
2						X
3				X		X
4						X
5						X
6			X		X	
7						X
8	X	X		X		X
9	X	X				X
10	X	X	X		X	
11	X	X	X	X	X	

Key to foregoing Tables:

+ = appropriate
- = inappropriate
= = indifferent
0 = unaware

Key to Abbreviations:

IGA = International Grenfell Association
I-S = Inuit-Settlers
Ineffect- = Ineffective

D. SUMMARY OF PHYSICAL ILLNESSES

In each case study it is evident that it is the specific set of circumstances which brought about the physical illness(es) coupled with the particular personality, status, and sex of the victim that will determine the kind and extent of treatment the patient will receive.

In Simiak's case, the many productive years that lie ahead of him, his affable and intelligent behaviour, and his repeated ability to demonstrate that he can overcome serious physical illness and accidents, result in gaining him community support. His case is typical of the more successful examples of handling of physical illness in the community.

Ellius' illness, to the contrary, demonstrates the more typical handling of physical illness in Nain. The necessary medical attention is given by IGA personnel, government subsidy will eventually make it possible for the family to survive (if only barely), but no effective plan of rehabilitation for the patient will ever be considered, let alone implemented. The reasons that operate to make Ellius' case different from that of Simiak's are principally related to age. Ellius' productive years are limited at 56 in the eyes of White administrators especially. With his specific illness, i.e., stroke, productivity along traditional lines is also impossible. Unlike Simiak, Ellius' has always led an independent life, retaining only loose ties with any social group in the village. This is not held against him, but it does mean that those who feel obliged to lend support in his present circumstances are few. Those who do intervene on his behalf do so as a result of the traditional role Ellius' holds, and for respect of that role.

Juliana represents the most severe limits within which physical illnesses can be ignored by the community. The reasons for this have been thoroughly discussed, however, in summarizing this section, I shall note Juliana's personal attitudes as I have done with the two previous patients. She is extremely intelligent, independent, defiant, proud, and able to endure both physical and mental suffering to an amazing degree. She does not avoid conflict, but does not seek it out. She is broken physically as a result of her years of ostracism, but her spirit and mind remain remarkably strong.

IV. MENTAL CONDITIONS

Specific cases of kauiŋnininit issumuk, "mental conditions" are dealt with in Nain solely by Inuit-Settler/Inuit. To be kauiŋnininit issumuk, or have a "mental condition" in Nain has little correspondence to the categories used in western medicine to distinguish such conditions (refer to the Illness Taxonomy in Appendix II). In Nain, all such conditions must be understood as experience that may lead to illness, but are not in themselves necessarily seen as mental illness despite classification as a "mental condition;" this term implies a need for restoration to one's original state, not change.

In this section, one case history will examine the situation of a young woman who was diagnosed as quajimmamijuq, "strange behaviour." She was seen to have a serious condtion, but not to be issumaitsissuq, "mentally ill." Usually, normal social support will work in such cases to restore the individual to his normal behaviour. The second case history involves a woman in her late twenties who was considered to be issumajaalukok, "seeing things," of a nature that eventually led to her being classified as issumaitsissuq, "mentally ill." The behaviour manifested by the woman diagnosed as issumajaalukok, "seeing things," had significant repercussions in the community's opinion. Differing from the young woman in the first case history, however, "seeing things" had serious implications in that it cast aspersions upon the character of her husband, the son of an extremely respectable member of the collectivity. By extension, her choice of things to "see" also resulted in bringing to the surface bitter memories from the past that long ago created a split between the two most prominant Inuit-Settler families in Nain. This split has, over the years, been negotiated so that necessary interaction between members of the two families can occur. By "seeing things" that, to those involved, reopened the issues of that previous episode and threatened to create, once again, hostilities that would be highly disruptive to the village as a whole, she had to be dealt with severely.

As mentioned in the introduction to this chapter, mental health problems were almost entirely restricted to handling through the native system of medicine. Only when these techniques failed and a patient became disruptive to the community would the IGA Nurse be approached by the family of the patient with the request that she send the patient away to a hospital in the south of Labrador or Newfoundland.

A. Ama (quajimmamijuq, "strange behaviour")

Ama was born in Nain in 1952, the fourth child in a large family. Her early years were spent in good health and relative happiness, for her family was from that subgroup of Inuit-Settlers who have remained more traditional in their orientation to the land.

From this it can be inferred that not only was there a fair degree of emotional stability in her early childhood, but that her physical health would have been good as well; her diet was undoubtedly among the best in Nain since her father and older brothers were able hunters. During those years she learned the duties of women from working with her mother and older sister, but also learned the duties of men, since everyone was needed to prepare the nets, and later, haul the fish nets aboard the boat.

When Ama was fourteen years old, her eldest brother was killed in a hunting accident. This changed the course of her life, and that of her family's, within a short period of time. The once close-knit family, living close to the land, independent from government subsidy and the church's demands, almost overnight ceased that way-of-life and settled into their old house in Nain.

Both parents, previously only light drinkers, turned to alcohol to relieve their suffering. The father tried to find work in the village, but his efforts were never adequate to support the large family through his own efforts and soon they, like many others in Nain, were on welfare.

As the family disintegrated, two children emerged to take over the roles of leadership: the next to the oldest son (the one just under the eldest who had been killed) and Ama, the second oldest female child. Although there was a daughter almost four years Ama's senior, she had already become heavily addicted to alcohol and additionally had a steady boyfriend with whom she spent all her time. The now oldest son became the primary hunter, and in the summer continued to attempt to carry out commercial cod fishing with little or no crew; when he did have helpt it was usually Ama and two or three of the boys ranging between 8 and 11 years of age.

But Ama took over the management of the house and the care of the younger children, some of them still babies. She was, as stated, only about fourteen at this time. Having a keen sense of responsibility, she tried in every way possible to assist her older brother "manage" her drunken parents, and hold the family together. This gave her a maturity in outlook and in personality far beyond her chronological age. Instead of becoming outgoing and carefree as one typically finds among Inuit teenage girls, Ama grew more silent and inward. She left school within a year of her brother's death, and no longer associated with her peers, for unlike them, she had now become a fulltime "mother" and "housekeeper" for the family.

It was during this period that her health began to fail, and it was discovered that she had tuberculosis. She was sent to the hospital, but being strong and resiliant, she was not kept long and sent home with medication. Immediately upon returning home she resumed the heavy household responsibilities and care of the children.

A girl, like Ama, could not date in the normal manner that prevails in Nain, for all her afternoons and evenings were occupied in duties necessary to keep the children and household properly cared for. She did not complain of her plight, but performed her duties obediently; the only thing that I could detect when observing her manner of disciplining the children, was that she was far more violent at times than one normally encountered in the handling of children by Inuit parents. Despite these handicaps she developed a secret relationship with a young man from one of the wealthier Inuit-Settler families. Had the boy's family known of the courtship, they would have put an end to it; Ama's family would have been seen as the most unfortunate choice imaginable in his parents' view.

During their courtship Ama became pregnant (this occurred while I was in the field). Many young girls become pregnant out of wedlock in Nain and nothing is thought about it. In fact, the father is usually open about being the father to the child, whether the two get married, or not. Contrary to previous situations of this kind, where if the boy did not admit being the father, the young woman would, Ama refused to divulge the young man's name. And he, being afraid, did not inform people of the village himself.

Ama went through her pregnancy without support of any kind. She experienced no physical difficulties throughout her term of pregnancy, and in fact, continued all of her heavy household chores and care of the family up to the final day of her pregnancy. When the time came for giving birth, she walked alone to the nursing station and without trouble, gave birth to a baby girl. The next day she took her baby out of the nursing station, and walked back to her parent's home. The following day she was back at the work of keeping house and caring for her new baby, as well as her siblings.

About one year after I had left the field, I learned that Ama had given birth to another baby, and like the first time, had refused to identify the father, and he still failed to claim the child. Few knew of his identity, and this, in a community so small as Nain, was quite a feat to accomplish. I, however, knew his identity through privileged information that was given me, and know that although Ama loved him, she would not force him into acknowledging the babies as belonging to him, seeing this as a test of his love for her.

Two years following the birth of the second child Ama attempted suicide. She got into a rowboat without oars and simply drifted out to sea. She was spotted by some fishermen returning from their day's work, and seeing her drifting in an oarless boat, went to investigate. She became enraged when they tried to persuade her to get into their boat, telling them "get the hell away from me, because I'm going to die!" The ensuing attempts to rescue her resulted in Ama jumping overboard. One man, trying to get her to grab hold of a jigger in order to prevent her from drowning was rewarded by her pulling the man into the water with her. In desperation, a man finally used a jigger to "catch" her by her clothing. In this way she was rescued from a death she did not want to be rescued from and brought back to Nain. She was now twenty years old.

The only change that occurred in her behaviour after her suicide attempt is that she began to participate in the family's drinking bouts.

Not long afterward, her younger sister got into trouble for throwing a rock through someone's window. This is a gesture young women in Nain use to "pay back" a boyfriend who has been discovered to be two-timing them. The RCMP Constable came to talk to the younger sister about the incident, and to make arrangements for her to repay the head of the house for the broken window pane.

When the RCMP Constable asked for the younger sister, Ama, in the performformance of her usual role of defending all the children, told the Mountie to leave her little sister alone, and to leave. When the Mountie became authoritative at this point, telling Ama to stay out of the affair, Ama physically attacked the Mountie, and despite his great size, did him considerable damage.

Both girls were tried in court. This court is, as previously mentioned, held in the back of the government store when the Magistrate from Goose Bay, Labrador, periodically flies to Nain to try the various cases of infractions against Canadian law that have transpired since his last trip. Both girls were found guilty, and sent to the women's prison in St. John's, Newfoundland, Ama for a much longer period of time than the younger sister she had been defending.

I have not heard whether Ama has yet been released from prison. Through mutual acquaintances I have heard how "ashamed" they all are that Ama had ended up the way she had. It was not her attempted suicide or jail sentence that had caused the Inuit-Settler/Inuit community to be "ashamed" of her; these are not uncommon in Nain. Her refusal to identify the father of her two children still disturbs the village. She took an unprecedented position in not revealing his identity for reasons that are new to Nain.

TABLE X: Breaches involved in Ama's Case

BREACHES	Ama	IGA Hosp.	Moravians	Ama's Parents	RCMP
1. Ama breached by refusing to identify father of two children born to her out of wedlock.	X				
2. Ama breached in making a suicide attempt to escape her circumstances.	X				
3. Ama breached by physically attacking the RCMP Constable.	X				
4. Upon contracting tuberculosis, the IGA Hospital & local nurse breached, re Ama's workload		X			
5. Members of Moravian school system made no attempt to prevent Ama from leaving school.			X		
6. Moravians did not intervene on Ama's behalf (re heavy responsibilities) even before breach			X		
7. Ama's parents breached by indulging grief to extent all responsibility fell upon Ama.				X	
8. RCMP failed to give consideration to facts that precipitated Ama's attack upon him.					X
9. RCMP failed to assess the effect of imprisonment upon Ama in view of previous history.					X

Breach #	Perception of Breach by Actors					Perception of Breach by Others			
	Ama	IGA Hosp.	Moravians	Ama's Parents	RCMP	White	Setlr	I-S	Inuit
1.	+	0	-	-	=	=	-	-	-
2.	+	0	-	-	-	-	-	-	-
3.	+	0	-	-	-	-	-	=	=
4.	-	=	=	=	=	=	=	=	=
5.	-	0	=	=	=	=	=	=	=
6.	-	0	=	=	=	=	=	=	=
7.	-	0	=	=	=	=	=	-	-
8.	=	0	+	=	+	+	=	=	=
9.	0	0	=	0	0	=	=	-	-

Key to foregoing Tables:
+ = appropriate
- = inappropriate
= = indifferent
0 = unaware

Key to Abbreviations:
IGA Hosp. = International Grenfell Association Hospital
RCMP = Royal Canadian Mounted Police
I-S = Inuit-Settler

	Analyst's Evaluation of Breaches					
	Dominant Culture: Effective Short-term	Dominant Culture: Ineffective Long-range	Subject Culture: Effective Short-term	Subject Culture: Ineffective Long-range	Reinforces traditional value system	Contributes to community Dissension
1				X		X
2				X		X
3				X		X
4	X	X				
5	X	X	X	X		
6	X	X	X	X		
7				X		
8	X	X				
9	X	X		X		

B. Bertha (issumajaalukok, "seeing things")

The following case history is in itself brief. It is used here primarily as a vehicle to examine the place that the traditional system of medicine plays in the handling of kauiŋnininit issumuk, "mental conditions" in Nain. Bertha's issumajaalukok, "seeing things" leads to a more detailed examination of how mental illness is perceived in Nain by Inuit-Settlers and Inuit. This is crucial to understanding the role of the negotiations that transpired in the handling of Bertha's case by members of the "negotiating collectivity." Although this does not exhaust the scope of disorders considered to be "mental conditions," it will illustrate the intricacies of this category of illness.

Bertha, a woman married to a man belonging to a socially prominent Inuit-Settler family, was taken to Northwest River Hospital for a mental disorder during the period of fieldwork. This is the ultimate failure of the community to solve the problem; aboriginally, it would have been solved through execution. According to the Inuit-Settler/Inuit informants the woman was "mental" for she was issumajaalukok, "seeing things."

I was told that Bertha had for some time been telling both relatives and people about the village things that, according to them, were untrue. Some examples of the kinds of things she was "seeing" included an account of her husband having placed a white-handled knife in his pocket and leaving the house. When he returned later he cried and told his wife that he had wanted to kill himself but could not. Another incident occurred during a visit from a relative, and she showed the guest some socks and said that her mother had given them to her just before she had died. Thirdly, the woman told people that their puppy had chewed up one of the mates to a pair of skin boots. None of these incidents were true, everyone said. Over a period of months such episodes led to Bertha's husband and other relatives reporting the woman's condition to the IGA Nurse with the request that she be sent away to a hospital.

When I asked a close relative to Bertha why she thought the woman was "seeing things," I was told "I think she's got something on her mind she needs to talk about." When I persisted, I was told that she thought the woman had been holding back something that she had done some years earlier and that these things had finally caused her to come to "see things."

TABLE XI: Breach involved in Bertha's Case

BREACH	Bertha
1. "Seeing things" or rather telling relatives and friends of episodes she thought to be occurring in the present as well as situations she said had occurred in the past.	X

Breach #	Perception of Breach by Actor	Perception of Breach by Others			
1.	Bertha	White	Settler	I-S	Inuit
	+	0	-	-	-

Key to above Table:

+ = appropriate
- = inappropriate
= = indifferent
0 = unaware

Abbreviation:

I-S = Inuit/Settler

Analyst's Evaluation of Breach						
Dominant Culture: Effective Short-term		Dominant Culture: Ineffective Long-range	Subject Culture: Effective Short-term	Subject Culture: Ineffective Long-range	Reinforces traditional value system	Contributes to Community Dissension
1.				X		X

C. Analytic Framework for "seeing things"

One may "see" certain things, including spirits, and be considered perfectly normal, while in other contexts he will be diagnosed as issumajaalukok, "seeing things." The following criteria was found to be used to distinguish between seeing things that are acceptable, and those that are not. Case histories included on this, and the following page, are of people who saw spirits, but were by no means thought to be experiencing a mental disorder.

Case History #6 (Personal Helping Spirit)

A man in the community of Nain, now quite elderly, suffered a serious accident when a young man which necessitated the removal of some fingers. The young curer who had charge of healing the man spent long hours at her task for the nature of the damage was such that all the fingers could have been lost. During the period in which she was in charge of the case she was continually subjected to abuse and threats on the part of the man's family. They were afraid that her youth and inexperience would fail to save the injured hand. The man recovered, but shortly afterward the curer died. Both the man himself as well as other members of the community relate how in times of pain he continues to experience, the spirit of the curer comes to him and relieves his pain.

Case History #7 (Shaman spirit in guise of an animal)

Some years ago there was a man who was a curer. He went in to the hills behind Nain hunting rabbits and after some waiting saw a large arctic hare. He began to follow the hare, but the hare went faster so the man had to run to stay with it. He was right behind the hare when it disappeared before his eyes. In the next instant the curer began to fall. The hare was in fact the malevolent spirit of a shaman guarding his grave in the form of a hare. The hare had led the unsuspecting curer to the edge of a cliff and then disappeared. The body of the curer was found dead at the foot of the cliff.

Case History #8 (Generalized Helping Spirit)

> Boas, a traditionally oriented hunter of great repute now living in Nain became lost several years ago in a severe snow storm. He abandoned his ski-doo and began walking in the direction he thought to be Nain. After many hours of walking and stumbling in a storm so severe that he could not see before him, he realized he was lost. He continued to try to find his way, but to no avail. Finally, he saw ahead of himself a figure beckoning for him to follow.
>
> He hurried to catch up with the shape ahead, but no matter how fast he moved the figure receded from him, continuing to beckon. He at last realized it was a spirit and resigned himself to following him without catching up. They walked for almost two days, the shaman spirit dropping bits of food for the hunter from time to time. When at last they came to within sight of Nain, the shaman spirit disappeared before the hunter's eyes. He went on into Nain, and told everyone of his experience.

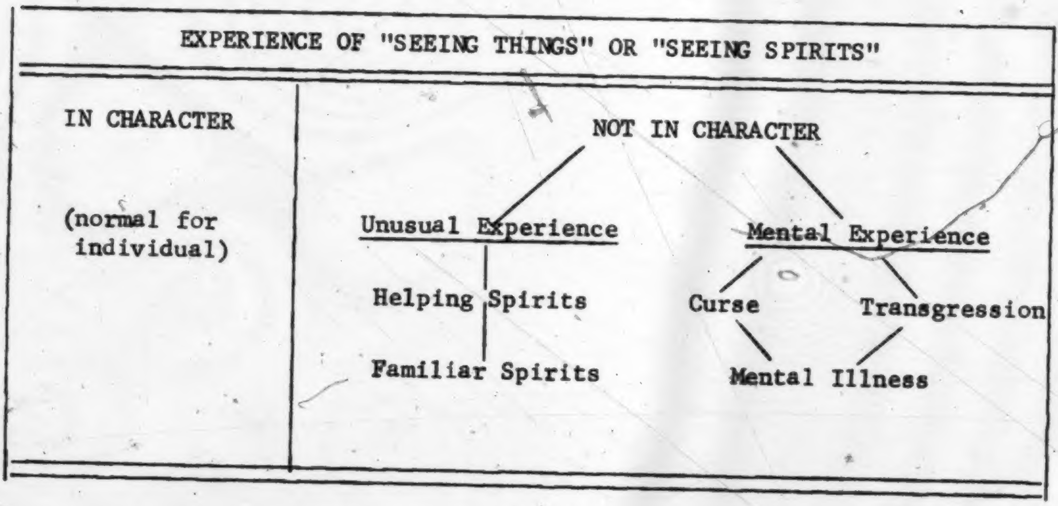
If the correct cultural response is made, the victim is rarely diagnosed as mentally ill. It is when the appropriate cultural response is not utilized that the community may change its diagnosis from that of an "unusual experience" to that of a "mental experience" and the concomitant possibility that one may be mentally ill.

Social relationships figure prominantly in the diagnosis and response of the Inuit-Settler/Inuit community to those who are "seeing things" or "seeing spirits" (as well as other mental conditions). Each individual will have his own network of acquaintances to whom he will turn when experiencing symptoms of any mental condition. In turn, each of these individuals exerts himself on his behalf to discover the nature of the problem. The final concensus reached by the community results from the input of a considerable portion of the Inuit-Settler/Inuit community's population.

1. (Analytic Premises)

Diagnostic criteria elicited in the construction of the taxonomy of illness was helpful toward understanding why certain instances of "seeing things" was considered indicative of a "mental condition" while others were not, but work with informants did not divulge a general level at which specific attributes would account for such variability in diagnosis. Thus, for analytical purposes, I created a more general level which would include instances of "seeing spirits" or "seeing things." Simply put, my analysis could not proceed as long as I continued to view each term in the category of "mental conditions" as sickness. This dilemma was resolved once I characterized all causes for issumajaalukok, "seeing things" and iugukssaq, "seeing spirits" as experience rather than sickness. The following schemata emerged once this substitution was made:

Figure 5: Approximation of Cognitive Processes


EXPERIENCE OF "SEEING THINGS" OR "SEEING SPIRITS"
IN CHARACTER
(normal for individual)
NOT IN CHARACTER
Unusual Experience
Helping Spirits
Familiar Spirits
Mental Experience
Curse
Transgression
Mental Illness

The preceding tree diagram approximates the cognitive process by which Inuit-Settler/Inuit make decisions regarding mental illness and accommodate all forms referred to by informants. The process evolves through the following stages:

a) If the experience is in character for a particular individual, then that is the end of the process; the community ignores it. Two extreme examples of such instances would be (formerly) in the case of one who was potentially a shaman and in another case, that of a congenital idiot. In the past the latter would not have occurred due to infanticide. In the present, the shaman no longer practices. This does not preclude the experience of "seeing things" or "seeing spirits" in individuals seen as normal, however.

b) If it is not in character for the individual, the question is asked "Is it a mental experience or an unusual experience?" Typical of unusual experiences would be a "helping spirit" as presented in Case Histories 6 and 8, or the spirit of a shaman in the form of an animal in Case History 7. If pathogenesis involves an experience seen as unusual, but reinforcing of the ethos of the community, then that is the end of the diagnostic process, and the incident becomes incorporated into the body of lore constituting a people's folk history.

c) If, on the other hand, pathogenesis is nonintegrative, the experience is seen to be mental. Then the question is asked "Is the mental experience due to a curse?" If so, others are looked to, e.g., "others" may include malevolent spirits acting independently as well as some individual in the community. If it is a curse, efforts are made to counteract the curse. If the mental experience is seen to be due to a transgression, then the nature of the transgression must be determined. Restitution follows in either situation as the community attempts to restore balance.

d) If the restitution taken does not correct the condition, then the individual is said to become "mental." Additional efforts may be taken by members of the community to correct the condition, but if such efforts fail and the patient is disruptive, the family reports the situation to the nursing station.

2. (Behavioural Criteria for "Seeing Things" or "Seeing Spirits")

The preceding analysis contributed substantially to an understanding of the Inuit diagnostic process, but still failed to adequately explain the criteria used by native speakers to decide whether an experience is integrative or nonintegrative of the ethos. This is an important factor, since one leads to acceptance while the other proceeds to more serious consequences, including a diagnosis of mental illness.

The behavioural correlates of social situation, social event, and social setting are seen to be important aides in determining the definitional meaning for informants when referring to different instances of "seeing spirits" or "seeing things." In an effort to identify the delimiting features by which Inuit do arrive at definitional meaning, the behavioural correlates of setting, event, and situation are employed at this stage in the analysis. I shall, at this point, identify Bertha's experience as Case History #9 (although in the series of major case histories presented in Chapter Five she is the eighth to be discussed), in the following figure.

Figure 6: Approximation of Evaluation of Events vis-a-vis Ethos

Social Situation	Social Event	Social Setting
Case #6 normal routine	Onset of pain	Home
Case #7 hunting	Death	Countryside near Nain
Case #8 hunting	Saved from death	"Outside", far from Nain
Case #9 normal routine	Interaction with others	Entire community

Figure 6 would seem to closely approximate the ordering of events by informants during the evaluative process. Since maintenance of ethos is the reason for evaluation of behaviour, I have attributed a (+) value to behaviour that is integrative with regard to ethos, and a (-) value to behavior which is nonintegrative.

Further analysis is possible once a means by which specific social events may be weighed. Figure 7 carries the analysis a step further in that it weighs the implications of the behaviour in each case history for maintaining ethos.

Figure 7: Approximation of Rationale in weighting Social Events

Case History	Implications of Behaviour	Ethos
#6	Satisfied need for a positive interpretation of a potentially disruptive event.	(+)
#7	Created the problem of an unexplained death.	(-)
#8	Reinforced traditional lore for lost hunters.	(+)
#9	Contradicted explanations preferred by the majority of individuals in the community.	(-)

By means of the preceding analytical framework, the logically possible models of phenomena is limited. Some Inuit-Settler/Inuit informants were conscious of the rationale by which such distinctions were made, while others were not; in both instances, however, the same conclusions were reached, i.e., that the event was either positive or negative in nature.

3. (Discussion of "Seeing Things" and "Seeing Spirits")

Cultural functions which were regulated by the diagnostic and treatment processes entailed in issumajaalukok, "seeing things" iugukssaq, "seeing spirits" coalesce to ensure social cohesion and the preservation of traditional culture. To illustrate, offences against others in the community, whether interpreted as moral transgressions, or curses, are perceived as serious problems. These offences are not taken to White agents such as the RCMP or the IGA Nurse for resolution, but are resolved within Inuit-Settler and Inuit social organization. The traditional means of correcting these situations, although altered, nonetheless, follow the essential traditional procedures whereby questioning, confession, and prescription of proper restitution still continue.

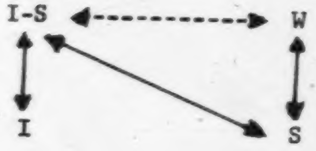
The same function is served with other causes of "seeing spirits." Beliefs regarding ancestor spirits and death are perpetuated in Nain by such acts as the placing of gifts on graves and the belief that spirits continue to play a part in one's daily life; the positive interpretation allowed the old man's "helping spirit" and the expert hunters' claim to seeing spirits in Case histories #6 and #8 further indicates the social function of iugukssaq, "seeing spirits" in maintaining traditional values. Whether Bertha's claim to "see things" were based upon factual events, or not, the claims she was making had an unsettling effect upon the community. When she persisted in that behaviour it was decided that her behaviour was disruptive and steps were taken to remove her from the community.

"Different social organizations breed different formulas for the social emotions and their expression. Under extreme social stress and deprivation these social emotions are the first to go. This leaves anxiety and rage which can tear a society apart" (Kardiner 1954: 169-180). Nain has been under stress and deprivation conditions in excess of 200 years. Its criteria for correct emotional expression (and the cultural premises from which they derive) were not the first to go. The importance of the category of *kauiŋnininit issumuk*, "mental conditions" as a regulatory social force are undoubtedly an important part of the formula whereby a traditional identity is maintained.

V. SUMMARY

Coping strategies related to the handling of illness in Nain have been shown to vary greatly in the actual working through of health problems.

Normally, the lines of interaction with regard to health (and other community matters) follow along lines indicated in the following diagram; only when these lines break down does arbitration take place that cuts across typical lines of interaction.



Negotiation, as a matter of fact, is the only way at present in which anything can get done at the community level, for Inuit-Settlers and Inuit do not like formal institutions, at least those not of their own making. They do not hesitate, of course, to honor regulations that have become institutionalized over time in their own culture.

Without doubt, the power held by White members of the "negotiating collectivity" is tremendous and usually allows them to direct activities relating to community health problems. Still, the Inuit-Settlers and Inuit have power at the community level that is not recognized by the White community (such power also extends to controlling some of the Settler population through marriage ties), that enables the native population to direct the course of community health problems to a greater extent than White administrators realize.

The collectivity's input into each type of health problem can be plotted along a continuum. At the end of the continuum that deals with community level health problems, Inuit-Settler/Inuit engage in open and purposeful interaction with powerful White members of the community (which does not exclude secretive and undercover efforts coexisting with this level of interaction) to achieve those objectives seen to be best for the native population. Because of its public nature, interaction of the collectivity's members could be followed in these kinds of cases. Once instances of individual physical health were the focus, activities of the collectivity became less conspicuous and less public. At best, the collectivity occupies a position on the continuum at mid-point in matters bearing upon physical health. Through my association with the akiterijuq, and the information disclosed to me by informants while engaging in research, I was able to reconstruct, in the majority of instances, what took place when people experienced "mental conditions." All activity relating to "mental conditions" within the native population was restricted to Inuit-Settler/Inuit members of the "negotiating collectivity"; hence at the end of the continuum that deals with mental health problems is entirely within the control of the native population.

At the community level flexibility typifies the collectivity's modus operandi, allowing structural fluidity in dealing with health and other emergencies. This usually works to the advantage of the Inuit-Settler/Inuit members of the collectivity; flexibility can, in some instances, also work to their disadvantage for formalized procedures that would ensure more equitable solutions are difficult to establish when such procedures are needed. A review of those tables accompanying community level illnesses indicate that when a crisis threatens the dominant culture, flexibility and the lack of formal guidelines that accompany it, are employed to the advantage of the dominant culture, e.g., See Table VI, page 164.

Cognitive dissonance operates in Nain to prevent a unified approach to physical health. At the individual level people receive inadequate health care since the objectives of the two medical systems are, at present, control of the population, not delivery of effective health care. Tables illustrating breaches in the cases of Ellius and Simiak indicate that few infractions were committed by members of either the subject culture or by agents of the dominant culture. Rather, as a consequence of concepts held by each cultural group, treatment and follow-up were not forthcoming -- each group blaming the other -- and by so doing disclaiming responsibility. Juliana's status overrode her need for medical attention, sanctioning inaction on the part of the Inuit-Settler/Inuit members of the collectivity and justifying inaction by the collectivity's

White members. Her case is representative of the impasse that occurs when coexistent systems of medicine function independently and with minimal knowledge of the other's principles. Under such conditions, joint-efforts toward the delivery of effective health care are precluded, particularly in cases that require judicious handling like that of Juliana.

Ama's case demonstrates the extent to which the native system of medicine is pressed to meet its obligations to its constiuency. Formerly her problems would have received attention. Today, she receives neither aid nor support from the native system of medicine or from western medical personnel. The native system of medicine's priority to maintain community cohesion allows room for only superficial attention to cases of individual stress. In contrast, Bertha's case received immediate and decisive handling, not because her mental anguish exceeded that of Ama's, but because Bertha threatened to disrupt the unity that is requisite to Nain's native population at this time, while Ama did not.

Today, Inuit-Settlers and Inuit define health and illness so as to defend themselves by the process of retrenchment. The personal costs to Inuit-Settler and Inuit members of the "negotiating collectivity" who must deal with the power differential continually rise; too, it is merely a matter of time before those among the native population who presently wield power will be replaced by another generation. Many among this generation have already lost much of the knowledge of, and desire to perpetuate, elements of the traditional culture.

THE EFFECTS OF THE "NEGOTIATING COLLECTIVITY" ON COMMUNITY STRUCTURE

CHAPTER SIX

I. INTRODUCTION

Interaction engaged in by members of the "negotiating collectivity" was, as reflected in the case histories, often affected by matters having little to do with health. In this chapter, some of the underlying principles that influence members of the collectivity when dealing with health and other elements that operate in the community are examined. Ideological/historical perspectives held by the collectivity's members derive from distinctly different sources; such an examination will serve to explain more fully the strategies followed by key individuals of each social group. In viewing the collectivity in this way there will be a shift in focus whereby matters of health are given less prominance, and general processes are dealt with to a greater extent. This is a deliberate shift taken for the purpose of isolating those ideological fundamentals of each group as they effected community structure.

PART I: Ideological and Historical Background of White Administrators.

A. MORAVIAN IDEOLOGICAL PRINCIPLES

The disparity existing between Moravian and Inuit-Settler/Inuit attitudes toward health and/or social regulation can be attributed to the basic differences each holds with regard to the nature of god and man, differences which originated in totally different cultural and ecological environments at widely separated points in history.

The Moravian Church, i.e., the Unitas Fratrum, dates from the year 1457 in Bohemia, the land of its birth, and the more spiritually minded followers of John Hus were its first members. Hus was a rector of the University of Prague and owed much of his religious enlightenment to the writings of Wyclif. In the seventeenth century the Moravians were invited to England. It was from this group in 1727 that a renewed wave of evangelism led the Moravians to inaugurate the modern missionary movement. They were the first Protestant Church that attempted to fulfill the duty of world evangelization and still maintain that emphasis.

Distinct characteristics of the church are:

1) Dispora; or promoting spiritual life and fellowship within the national framework,

2) Education; long recognized as characteristic of the Moravian missionization policy is the establishment of schools, including boarding schools,

3) Missionary Zeal; this characteristic feature of Moravianism has not waned since 1732 and has sent forth individuals on an uninturrupted basis, in some cases through five generations of the same family. The church's energies flow largely along this channel. In the Protestant churches the proportion of missionaries to members is about 1 to 5,000; among Moravians it is 1 to 60.

Moravian Doctrines and the basis of their belief system are defined in the "Church Book" under the following heads:

1) the doctrine of the total depravity of human nature,

2) the doctrine of the love of God the Father,

3) the doctrine of the real Godhead and the real humanity of Jesus Christ,

4) the doctrine of our reconciliation unto God and our justification through the sacrifice of the cross,

5) the doctrine of good works as the evidence of faith,

6) the doctrine of the fellowship of believers,
7) the doctrine of the Second Coming of the Lord, and
8) the doctrine of the Headship of Christ over the Church.

Thus, in essence the theological position is that of the Nicene Creed, the XXXIX Articles, the Augsburg and the Westminister Confessions. The Holy Scriptures are regarded as the only rule of faith and conduct and the basis of all teachings as well as the final court of appeal (Encyclopedia Brittanica; Hastings 1967: 837-841).

The Moravians are not a medical mission; their directives are evangelical. From the beginning, however, their approach to missionization included the treatment of health problems in the Inuit community of Nain. This was not a deliberate choice on the missionaries' part, but one of necessity. Health of converts was rarely supervised by trained medical personnel, but more often was treated by missionaries without professional medical training. This practice continued until 1951 when the IGA stationed a nurse permanently in Nain.

Because of the Moravian's involvement in the health care of the native population of Nain throughout two centuries of missionization, information relating to medical problems experienced by members of the community are still considered to be the privileged right of Moravian missionaries. The missionaries' access to personal medical information pertaining to the Inuit-Settler/Inuit population must be understood in the context of the former scope of mission activities. In the not too distant past (until 1926), the mission controlled all aspects of Nain life. Today, although certain areas of responsibility have been relinquished to other agencies, e.g., IGA, DNLA, and RCMP, these organizations have few automatic rights, for the land upon which Nain is built belongs by deed to the Moravian Mission.

Moravian ownership of the land has ramifications not only for the health of Nain's citizens, but for the future of Nain. Through long-standing association with the IGA in Labrador, mutual cooperation has come to represent the form of interaction between the two organizations, consequently, the IGA accepts the church's criteria in matters of health that become subject to moral interpretation by the Moravians, e.g., birth control, sex education, and the like. Officially the DNLA is an arm of the Newfoundland government whose purpose is to implement specific economic-environmental-social changes in Nain. Nonetheless, the Church dictates to a large extent the form these changes will take because of the fact that such changes are actuated upon Moravian property. The RCMP is the national government's law enforcement agency in Nain with alleged powers above those of local authority. The fact of land ownership by Moravians overrides such powers in Nain, for the minister takes the right to intervene in functions normally closed to those not duly authorized by Canadian law with both the local RCMP and the Magistrate from Goose Bay, both of whose decisions are subject to his sanction in reality.

Ownership of the land by Moravians has been responsible for the class system that now exists in Nain. White Settlers who married Inuit were from the first given preferential treatment, separating them from the Inuit by language, economic access to outside resources, and educational opportunities. Church records indicate how when the early Inuit families moved into the village of Nain, they were told they could not receive supplies from the Moravian stores or live in Nain if they continued to associate with their "heathen" relatives who remained on the land away from Nain. The substantial hostility that exists today between some members of the Inuit-Settler and Inuit population is a direct result of the Church's efforts to impress upon the Inuit-Settler of Nain that the newly relocated Inuit were inferior to them, since the Inuit-Settler had received benefits culturally, economically, and educationally, to which the new arrivals had in most cases not been exposed.

B. THE IGA'S IDEOLOGICAL/HISTORICAL BACKGROUND

Principally an evangelical mission, the Moravians nonetheless practiced medicine among the Inuit of northern Labrador for over a century and a half, while the Interantional Grenfell Association -- primarily a medical mission -- acted from its inception in the capacity of religious evangelists among the southern Labrador Inuit. Each emphasized its principle objectives, but the fact that both were Protestant missions was an important factor; their views of god and man were compatible and constituted a common ground for cooperation in the administration of health care and social regulation.

The original founding organization of the IGA, the Royal National Mission to Deep Sea Fishermen of London was established by the Protestant Evangelical Church of London in 1882 (Kerr 1959: 29). In 1892, Wilfred Grenfell, a young doctor and religious zealot, was given authority to promote both spiritual and temporeal welfare among those to whom he ministered along the Newfoundland and Labrador coasts (Encyclopedia Canadiana 1965: 38).

Grenfell immediately launched the Royal National Mission to Deep Sea Fishermen into many aspects of Labrador life that had little to do with either medicine or religion. He was a magistrate appointed by the Newfoundland government to act on their behalf whenever he encountered infractions seen by him to be contrary to Newfoundland's legal, political, or economic welfare. He founded and directed the affairs of hospitals and nursing stations in Labrador and Newfoundland. He established and supervised sawmills and cooperative stores on the Newfoundland-Labrador coasts and at one point imported reindeer herds and Lapps to manage them to Labrador, but this venture failed to prosper (Townsend 1907: 275-280). There is a "Grenfell cloth" used in the manufacture of coats now worn by Inuit and Settlers in Labrador which is operated by the IGA. A commercial arts and crafts enterprise of international magnitude exists at the hospital in St. Anthony's, Newfoundland, which uses Inuit patients to produce the products for this establishment. Numerous other business ventures were undertaken by Grenfell, many continue today, of which the above examples are typical.

By 1905, Grenfell began to experience difficulties with the Royal National Mission to Deep Sea Fishermen in London due to his autocratic ways. In 1912 Grenfell asked the mission to hand over all its accounts relating to his work to the associations he had organized in the United States. These associations were the source of revenue for his non-medical and medical activities and were under his personal direction. After several years of dispute, the Royal National Mission to Deep Sea Fishermen gave the IGA a 99-year lease on the mission's properties, and shortly after 1927, handed over everything to the United States' based International Grenfell Association (Kerr 1959: 181-194). This association, like that of the Moravian Church tends to remain within the dominion of family lineages; such an alliance of kindred presently establish policies relating to the health care of the Labrador Inuit as well as supervise their various commercial enterprises.

Moreover, the object of the IGA has never been to incorporate facets of the native system of medicine into their program. In a book written by an employee of the Hudson Bay Company for the purpose of instructing Inuit in matters of correct religious, health, and hunting practices, the indigenous system of medicine is dismissed by the following introductory statement to the section on health:

> "The first rule then in curing sickness or injury is to OBEY THE INSTRUCTIONS OF THE WHITE MAN (Binney 1931: 144)" (Capital letters are theirs).

The Eskimo Book of Knowledge from which this excerpt was taken was coauthored by the Moravian Superintendent of Labrador and Sir Wilfred Grenfell of the IGA, who acted in an advisory capacity for the book.

I was unable to determine medical policies or forms of treatment followed in IGA facilities with respect to the Inuit for several reasons. Although Grenfell wrote prolifically, he wrote principally of his own adventures in Labrador; medical treatment of the Inuit was generally related in anecdotal form in his books and nothing can be learned about medical procedures followed in those early years from such material. Contemporary studies are equally restricted, for scientific research is not encouraged, and I could find little in the professional journals reflecting either formal research activities or even casual findings authored by medical personnel presently in the employ of the IGA. I was denied entrance to their North West River facility for purposes of research with the following rationale:

> "...we cannot permit his efforts to explain his own ideas about himself collected by any third party as scientific data. Many of these patients are very shy about their lack of knowledge and embarrassed by betraying it, and such people do not like to find out later that incorrect conceptions of theirs have been collected as interesting specimens by a research worker" (personal communication from a key IGA medical director).

The philosophical and ideological bases of the IGA that have motivated health care to Labrador Inuit over the past 85 years can, however, be described in a general sense. Based upon personal interviews with its Director, several of its professional staff at the St. Anthony's hospital, personal correspondence at another hospital facility, and many conversations with the IGA Nurse in Nain, I found a marked paternalism to exist among all personnel toward the indigenous population they served. One can only speculate, in view of the lack of evidence, what effect the IGA's many business enterprises has had upon the kinds of policies followed in delivery of health service to the Inuit population.

Answers provided by the IGA Nurse in Nain to a questionnaire I asked her to complete do allow evaluation of the effects of IGA's overall health program in Nain. The following represent only a partial excerpt from my questionnaire:

Question:	Have you been able to determine to what extent your medical prescriptions and advice have been followed?
Answer:	"Yes."

Question: If you can make some comment on this question, in what way would your advice be expected to be taken in the following categories:

a. The taking of medicine in the manner prescribed?

Answer: "Poor."

Question: b. The cutting down, or refraining from a given workload if told to do so.

Answer: "No."

Question: c. Would men follow instructions to cut down on workloads best, or would women?

Answer: "Neither."

Question: d. The abstaining from sexual relations (for reasons of health).

Answer: "Very poor."

Question: f. The abstaining from brew, or alcoholic beverage generally.

Answer: "Very poor."

Question: g. Do people honor your "decree" that a particular illness/disease syndrome is highly contagious and refrain from social interaction while ill?

Answer: "No."

Question: h. What is your learned guess with regard to the general health trends for Nain for the next five years?

Answer: "On the whole -- unchanged."

After thirty-four years in Labrador and twenty years in Nain, the IGA Nurse realistically appraises the limited impact of western medicine upon Nain Inuit-Settlers and Inuit.

C. SUMMARY OF PART I

Ethnocentric bias of Moravian and IGA personnel is typified in the writings of Dr. S. K. Hutton, a Moravian missionary and medical doctor stationed in Labrador at the turn of the century:

> "If an Eskimo has pain in any part of his body, that part is to his way of thinking, broken. And similarly, if a man has a bad cough, his lungs are broken and so on. The woman who came from the snow frozen huts at Killinek to live in her brother's wooden house at Okak, and found the warmth more than she could endure, used just the same expression when she said 'my life is broken.' This is the idea upon which the native doctors work: something is broken, and must be mended" (Hutton 1912: 288-289).

Doctor Hutton's perspective is not outdated among professional personnel of either mission. He, like they, has failed to investigate in an unbiased manner terms encountered when speaking with the Inuit who, trying to communicate in English, use the word that only approximates the Inuktitut meaning. "Broken" was a term I frequently encountered while in Nain to describe illness or impairment, but the meaning divulged by informants for "broken" was that something did not function properly; something was out of order in the body. To indicate this, the word-medial morpheme, /-illi/, follows an initial noun and indicates the "breakage" or "serious impairment of function" of the same (Spalding 1969: 74-77). Examples are the following:

tunnuillijuq = "he damages his back"
kannaŋillijuq = "he breaks his shin-bone"

The IGA Nurse in Nain was similarly "blocked" from the ability to acknowledge the native medical system, for when telling her of the work I intended to carry out while in Nain, she said that she did not think I would have much success, for as far as she knew Nain Inuit had only one word to describe illness, that being nuvak, "common cold." She professes to speak Inuktitut, but informants said her knowledge of the language was superficial. The Inuit community apparently wants IGA out of health situations they themselves can handle so this may be a good mutual adjustment.

Without constant "social work" on the part of the subject culture throughout two-hundred years of contact, Moravian and IGA personnel would undoubtedly have succeded in bringing about fundamental changes in the Inuit-Settler/Inuit concepts about health in particular, and their ideology in general. This has not occurred because an unbroken line of Inuit-Settler/Inuit individuals have met each new demand for change by negotiating continuously matters that affected those areas of importance to the Inuit culture.

PART II: Ideological Background of Inuit-Settler/Inuit.

Unlike the Protestant deity, the traditional Inuit deity was metamorphic in nature, with the sun and the moon representing both male and female elements of a single deity. Their deity, like man, forever underwent changes of a significant nature. While living out each existence, man may be altered at various stages of his existence through metamorphic transformation of his spiritual identity, as when one becomes a shaman. Reasoned from this basic premise, death is simply a time of temporary discontinuity; life will be resumed, not when the soul rejoins the deity, but when the "Name soul" is again given to a newborn infant (Frederiksen 1968: 48-54).

Labrador Inuit conceive the female aspect of their deity, Nuliajuq, to be the "Mother of the Beasts," and, significantly "Nuliajuq Night" is still celebrated by the village of Nain. The akiterijuq explained to me that "...Nuliajuq Night is to us people something like what Christmas is to you people; the young are reminded of our old god on Nuliajuq Night and to respect their elders because they still know the 'way'." Only in Siberia do the Inuit of Indian Point continue to sacrifice to the "Old Woman of the Sea," Nulirah, i.e., Nuliajuq being the equivalent in the Nain dialect. The male aspect of the deity, Torngarsoak, is seen as presiding over both the spirits of slain animals and the future supply of animals. He is said to live in a cave in the Torngait mountains at the northern extremity of the Labrador peninsula and takes the form of a large bear.

Of further importance is that the part of the soul which originates from the deity, unlike the Christian concept of the soul, is not the element which has a continuing existence. Simply put, this means the "hereafter" does not play any part in Inuit beliefs about illness and death. Illness is a problem in the present due to one's inability to function. Illness that leads to death is not that important, since renewal will occur when that part of their soul is transferred through renaming a new infant.

Hence, the Inuit composite soul is formed from two distinct sources, 1) the Corporeal soul, i.e., "Universal soul," "Life soul," that is derived from the deity and is present with the embryo at the time of conception, and is that which becomes attached to the physical body of the individual, i.e., inua, "vital force" whose function is to repair, heal, and maintain balance within the individual, and 2) the Non-corporeal soul, i.e., "Individual soul," "Name soul," or "Image soul," which is merged with the corporeal soul through the process of "naming" the infant. The child is in a sense made a member of the human community at that time. Although this ceremony has been partially eroded in Nain, certain characteristics that attest to the continuing importance of the traditional concept are present, e.g., the name given the child is seen to carry with it the spiritual qualities of the individual for whom the child is named. Further, the spirit of the deceased is thought to protect the child throughout life. Sex differentiation is still not used (necessarily) in selecting children's names in Nain. Children are also named for both the living and the dead in Nain, but the same distinctions apply in either case.

At the time of death, the corporeal soul remains with the body, while the non-corporeal soul splits away, awaiting its continued existence through the "naming" ceremony. It is during that period before it has been given renewed existence that Inuit fear the soul's potential actions, e.g., vengeful, restless, or "evil" spirits.

It was the traditional healer's function to diagnose and then determine the correct means by which the soul's elements would be kept in balance -- for illness befell those whose soul and/or body had been brought to a state of disequilibrium -- with the community and the rest of the universe. This responsibility does not fall to all who are designated as shaman, for Nain Inuit see shamans to possess different degrees of power. The akiterijuq, for example, was seen as a "lesser shaman," with no derogatory connotation implied. Her scope of power, however, extended to both the sacred and the secular. That is, the akiterijuq's role in healing was, in reality, one that involved a responsibility for the health of the Inuit-Settler/Inuit population as well as the overall state of the community. Thus, her role as healer, in many instances, was an activity engaged in to obscure from Whites, and at times Inuit-Settler and Inuit, her actual objectives, to ensure a quality and kind of life important to the culture she represented. Only the shaman from Killinek was seen to have powers beyond those possessed by the akiterijuq. His present activities, are, as previously noted, unaccessible to researchers.

II. THE EFFECTS OF "SOCIAL WORK" BY THE "NEGOTIATING COLLECTIVITY"

Strategies employed in the solution of health and other problems encountered by the collectivity differ greatly between social groups, and show a variety of coping techniques to be utilized. The nature of this "social work" can be followed by looking at some of the most common techniques and their effects on the community.

1) Negotiation -- or arbitration -- among members of the collectivity did not necessarily lead to change in the cognitive structure of their constituency, in fact it rarely did. Negotiations are usually undertaken to accommodate a particular situation; at this level the decision-making procedures are conscious. But, the fact that the group is "unchartered" (with the concomitant degrees of consciousness that operate in such groups) meant that cognitive changes embedded in the problem-solving process had no way of being fed into recognized insti-

tutions in the community and through them, a means to change the cognitive structure or map of the population. But then, the desire for change among the Inuit-Settler and Inuit has been restricted to specific domains: technical knowledge and access to outside resources, for example.

2) By the same token, negotiation does not change "knowledge" about the effects of behaviour, or the underlying causes and actions associated with the problem that has been negotiated. Arbitration of health matters usually proceeds in such a way that one is not educated, e.g., in the venereal disease situation, for the same reasons that cognitive structure is not modified.

3) Changes in behaviour that are a consequence of interaction between members of the "negotiating collectivity" are temporary, for the most part. During the hepatitis epidemic, behaviour was changed minimally and briefly because contingencies forced change at that time. A future hepatitis epidemic would not necessarily benefit from the handling of the crisis, for variables would have changed in the interim which would result in a different solution being required in the new crisis. A primary factor of this system is its flexibility to deal with different combinations of variables in different situations.

4) When negotiating matters that bear upon health in Nain, many variables of an unpredictable nature effect the interaction that takes place between members of the collectivity. Some of the variables result from a particular alliance being formed because rewards are seen to be attached to the handling of the problem along certain lines.

Alliances, except those based upon bonds of kinship or between those with shared cultural values and economic interests in a given outcome, are brittle; alliances can come into existence one day and be dissolved the following day by those lacking the aforementioned bonds. At times, even shared cultural identity is inadequate to maintain an alliance -- as found in the hepatitis epidemic -- but a vested interest in the economic benefits to be gained through alliances will normally hold such groups together longest, e.g., the oil shortage.

5) Other variables that effect the form of arbitration between members of the collectivity are related to the absence of one or more members of the group when a "situation" arises. This frequently happens, particularly among Inuit-Settler/Inuit members who are away from Nain for long periods of time during the summer months, and for days or weeks during other seasons of the year engaged in subsistence activities. As noted in Chapter One, proxies do not operate in the absence of a member of the "negotiating collectivity" from the community.

7) Some variables, to the contrary, may act to ensure more predictable forms of negotiation between members of the collectivity. Among these would be kinship affiliation. The only factors that take precedence over kinship or social group affiliation are community codes of behaviour among the Inuit-Settler/Inuit population, e.g., the case of Juliana, and vocation-related constraints among the White population. A further observation with respect to the primacy of community codes of behaviour among Inuit-Settler/Inuit, is that these

codes are binding whether they remain traditional in nature or have undergone change through time, but have not as yet become those based upon EuroCanadian standards.

8) Occasionally it happens that a problem bearing on health -- and other matters as well -- arises that is so complex, or foreign to anything previously encountered, that no guidelines exist, or perhaps the negotiation of the problem seems to promise no advantage to any particular segment of the community. In such cases, if the problem is sufficiently pressing so that it cannot be ignored, innovative solutions sometimes emerge. During the oil shortage several innovations could be observed:

a. The selling of church oil without the consent of the church authorities,

b. the selling of inflammables normally not used for stove fuel,

c. the stopping of work on the school's new wing to allow more oil to be distributed within the village,

d. the use of rumor purposely to bring the issue to the public's attention, and

e. the final overland shipment by way of komotik cavalcade in order to bring oil to Nain.

Innovative solutions may also occur where the different ideological factors are so sensitive that only innovation is likely to bring about a resolution, e.g., the syncretism that has evolved through time to accommodate both Moravian and Inuit-Settler/Inuit concepts with regard to what "Young Men's Day" should incorporate. Moravians outline the day's activities to focus upon a series of lectures seen to be beneficial to young men and church services throughout the day, but the native population has secularized these activities to include:

a. The pre-celebration hunting parties made up of young men and headed by a more seasoned "young man." It is their objective to secure food for the upcoming feast, but it is also a time during which older "young men" set difficult tasks for the initiates for the purpose of testing their skills,

b. the engaging in traditional games in the early evening when the church functions have been concluded by all young people of the community, and

c. the arrangement whereby young men who have not yet been initiated to sex will be given the opportunity to do at the evening's end, and still others.

Although the aims, techniques, goals, and principles of each social group of which Nain is comprised are different, it is still a single community. It is apparent that a great deal of "social work" by members of present and past collectivities has resulted in a degree of cohesion that allows people to live together in Nain despite ideological differences and the power differential that has been achieved by Whites.

What must be differentiated between what the collectivity's activities accomplish in general, and its activities as they effected cognitive change, is that the "negotiating collectivity's" primary importance was not to be found in its problem-solving capacity *per se*, e.g., change of cognitive structure, negotiation, or innovation; these are consequences of its activities, but are by-products of a series of actions that operate at a deeper level and for a purpose more pressing upon members of the collectivity than the solution of any single health or other community problem. This deeper function is to preserve each social group's belief system and to guard those "elements" which comprise that system, whether they take economic, technological, or health form. The Whites, and to a lesser degree, the Settlers, invest most of their identity in ways of life and institutions that have their roots in similar historical and ecological settings. Inuit-Settlers and Inuit, on the other hand, fight a battle of retrenchment, guarding their beliefs about health and other "elements" upon which the daily realities of their lives are formed, "elements" which are intricately related to an entirely different history and environment.

As an undeclared, virtually unconscious interactional structure, it has consequences of the utmost importance in Nain (Unconscious in this context refers to the fact that the "negotiating collectivity" is not a formal decision-making body. It also refers to the identity of some of its most powerful members being totally unknown to others of the collectivity). Whether the collectivity arbitrates matters bearing upon health, or the price to be paid per pound for cod, interaction serves to protect the vested interests of each major cultural group. Maintenance of the subject culture may be unusual in Nain, since there is change, but so far without the loss of an integrated baseline of values.

Formal means for solving problems, e.g., Canadian law, the Community Council in Nain, the policies of the IGA, and Moravian precepts are supposed to be the channels along which particular problems are solved, but each is characterized by precedents that in many cases are antiquated, and in almost every instance, both too rigid and too time-consuming to accommodate the problems that arise on an almost daily basis in the lives of the community's inhabitants.

When people holding important positions in Nain find themselves in situations that require a response that is too immediate or too unorthodox to be handled through these legalized institutions, the pressures stemming from the struggle for identity maintenance and/or survival, propell them to enter into arbitration on an ad hoc basis. Inuit-Settler/Inuit have limited access to these institutions in any event. Both dominant and subject cultures participate in ad hoc arbitration in Nain, for the struggle for each social group's belief system is of such importance that if steps are not taken for effective resolution (in keeping with what each group sees as effective), irretrievable cultural "elements" will become lost.

SUMMARY AND CONCLUSION

CHAPTER SEVEN

I. INTRODUCTION

The foregoing chapters have systematically presented the ways in which decisions about health are subject to arbitration by representatives of two major cultural groups in Nain, Labrador.

My focus upon health-related events indicated, nonetheless, that the general processes that operated with respect to health and illness often applied to other domains. Social interaction would, for example, be initiated for the alleged purpose of resolving a health problem, but exigencies that overrode health invariably took precedence. In such cases, the basic processes by which negotiation had begun did not have to undergo any significant change. In form, these situations involving arbitration were not unique; the power differential was almost always disproportionately in favor of the Whites, leaving representatives from the subject culture the option of deciding their most advantageous strategy within the process of retrenchment.

II. THE FUTURE OF THE "NEGOTIATING COLLECTIVITY"

The "negotiating collectivity" has worked to perpetuate principles its members saw as requisite to maintenance of their belief system, and through it, their cultural identity. Viewed dispassionately, it is clear that in recent years their efforts are unequal to the contingencies that affect all matters that transpire in Nain, and Labrador generally, i.e., the struggle for economic and territorial control from outside institutions. Many Inuit-Settler/Inuit members of the collectivity felt the personal costs of arbitrating with the dominant culture had already gone beyond their ability to adequately cope. Negotiation between members of the collectivity increasingly ended in serious negative consequences for the native population.

I submit that due to the rapidity with which change in the priorities of members of the collectivity have occurred, that without immediate input from the Inuit Taparisat, "Eskimo Brotherhood," or other appropriate institutions, even the benefits associated with its being to some extent simply a "holding" process will no longer be available to the community's inhabitants. With unfailing consistency "solutions" can be bought by the highest bidder, for some Inuit-Settler and Inuit members have become victim to monetary recompense, and arbitrate along lines that have little to do with maintenance of health or cultural identity, but much to do with furtherance of vested interests.

Intervention from the Inuit Taparisat of Canada, or any other institution, would not be easily accepted, for Nain Inuit have valiantly maintained their cultural autonomy while subject to several devastating forms of contact over 200 years. There is no assurance that input of a constructive nature from any organization, including the Taparisat, would be accepted. The Taparisat are outsiders, even though they are Inuit. Dozier's analysis of the Tewas' success in perpetuating their cultural autonomy disclosed that the ability to do so lies primarily in the use of psychological techniques to maintain a cultural boundary between themselves and the White culture (Dozier 1955: 242-257). Any efforts now to make a positive contribution to the Inuit society of Nain, or Inuit living elsewhere, must do so with this in mind; any steps taken to cross these cultural boundaries in order to bring into existence better health care and restore self-regulatory mechanisms will not be easily accomplished.

III. CONCLUSION

No conclusion of my own wording could summarize the content of this thesis nor the events that marked its period of preparation more accurately than the following quotation from Kierkegaard. The interpretation to be given the term "primitive" is that given it by Stanley Diamond in his article "The Search for the Primitive" (1963: 62-115):

> "As soon as a man appears who brings something out of the primitive along with him, so that he doesn't say, "you must take the world as you find it," but rather "let the world be what it likes, I take my stand on a primitiveness which I have no intention of changing to meet with the approval of the world," at that moment, as these words are heard, a metamorphosis takes place in the whole of nature.....dark, uncanny demons, who have been sitting around doing nothing and chewing at their nails for a long time, jump up and stretch their limbs, because, they say, here is something for us..."
>
> — Kierkegaard

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THE ORTHOGRAPHY

APPENDIX I

When eliciting the illness terminology, each session with an informant was taped in order to get a permanent phonological record of the sound system used by Inuktitut speakers in this community. Simultaneously I recorded on paper the morphemic structure as I perceived it.

No standard orthography exists at present for the Inuit of Labrador. One mimeographed dictionary written by the Moravian Superintendent of Labrador, Reverand Peacock, was available to me, but in testing its approximation to actual speech of the Nain Inuit, I found little correspondence. It was, consequently, not used.

Smith's work (1975) with Labrador surface phonology provides a good historical background to work of a linguistic nature carried out by Moravian missionaries. It does not, however, reflect Inuit usage other than that developed by the missionaries. For the same reasons that I found Reverend Peacock's work unacceptable, I found Smith's work with the Moravian orthography of little value in the actual terminology to be used in this thesis.

Upon return from the field, I attempted to find an acceptable guide to the Eskimo language only to become aware of the very real lack of substantive material of this nature. Despite some criticism of A. E. Spalding's Salliq: An Eskimo Grammar (Spalding 1969: 1-128), I have found it useful in contrasting the linguistic and grammatical features of the Nain dialect.

On the following pages the orthography for the medical (and related) terminology used in the thesis will be presented. The orthography is adopted from Gagne's *Tentative Standard Orthography for Canadian Eskimos*.

This version of the orthography has had the advantage of correction by Dr. Albert Heinrich, cognitive anthropologist, Dr. Regna Darnell, linguistic anthropologist, and Dr. Anthony Vanek, linguist.

The graphemic code consists of fourteen consonant symbols, p, t, k, g, m, n, ŋ, rŋ, v, s, j, g, r, l; three short vowels, i, a, u; and three long vowels, ii, aa, and uu. Each consonant germinates except r and rŋ, and each consonant occurs as the second member of two-consonant clusters after r, except k, _, r _, g, and r.

TERMS OF ILLNESS

adjuŋillitisisisuuq	"abnormal conditions"
aitulunaaqtuq	"venereal disease"
ajuak	"boil"
ak	"little fits"
akeaguligijuq	"mild stomach ulcer"
akiterijuq	"curer"
anagak	"diarrhea"

I have found it useful in contrasting the linguistic and grammatical features of the Nain dialect.

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adjuŋillitisisuuq	"abnormal conditions"
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ajuak	"boil"
ak	"little fits"
akeaguligijuq	"mild stomach ulcer"
akiterijuq	"curer"
anagak	"diarrhea"

anagunna ituq	"constipation"
aniak	"ache"
angakok	"shaman"
anuaq	"amulet"
aniniŋitssaq	"shortness of breath"
anitigisuugunnaŋi umaqattatuq	"serious asthma"
aouk	"blood"
aougiak	"blod clot"
aounga ingusiuŋituq	"poor circulation"
aoungagigunnaŋijuq	"hemorrhage"
aounagalajuq	"bleeding heavily"
aouqatsiaŋituq	"anemia"
aunik	"tooth cavity"
aupalukijuq	"inflammed"
ausikuugiak	"pain while thawing"
eczemajuq	"eczema"
idluilliq	"sprain"
illiksiniq	"curse"
illuiq	"snowblind, permanently"
illusiluttaq	"deformed"
inua	"its owner; vital force within"
ipelaʔlaaq	"profuse sweating"
issuma	"thought"
issuilliq	"dislocated shoulder"

issumaitsissuq	"mental illness"
issumajaalukok	"seeing things; and extremely nonsensical thoughts"
issumaluttaq	"retarded"
issumaŋa illuitunngituq	"imbicile"
issumaqatsiannigituq	"insanity"
issumataq	"leadership by oldest males"
ittiga illusillok	"clubfoot"
iugukssaq	"seeing spirits"
iyeluk	"irritated eyes"
iye atillugujauq	"black eye"
iyek immalik	"watering eyes"
Kaaluk	"scabby sores"
Kadlunat	"White Man"
kannaŋillijuq	"broken shin-bone"
kannimmaluk	"critical sickness"
kannimmuksauluk	"warning of serious sickness"
kannimmuksaussaq	"potential sickness"
kanniuiŋnininit issumuk	"mental conditions"
Koasimajuq	"frost bite"
kaujimmaŋituq	"coma; out of touch with reality"
kelujiq	"cramps"
kidsuuq	"scratch"
kiliq	"small cut"

kiluluttaq	"harelip"
kimimut kiijausimajuq	"dog bite"
kinetdlika puiŋillivuk	"severely swollen glands"
kingak aounaajuq	"nosebleed"
kiujaaluk	"chills, accompanying sickness"
Kupiksimajuq niaqnatasauninit	"fractured skull"
mesilsi	"measels"
naanguq	"belly ache"
nakgoailligiq	"arthritis"
nakungaq	"cross-eyed"
niaqunguq	"headache"
nukiqaŋituq	"weakness"
numoniaaq	"pneumonia"
nutsuksiq nukimik	"pulled muscle"
nuvak	"common cold"
okalagunnaŋituq	"mute"
okkommaidlualuttuq	"overweight"
olik	"chills; due to exposure"
omatiluttaq	"heart trouble"
onartuq	"fever"
pannituq amik	"chapped skin"
peilinik	"underweight; from excessive sex"
piatuqatsaeinatut	"alcoholic"

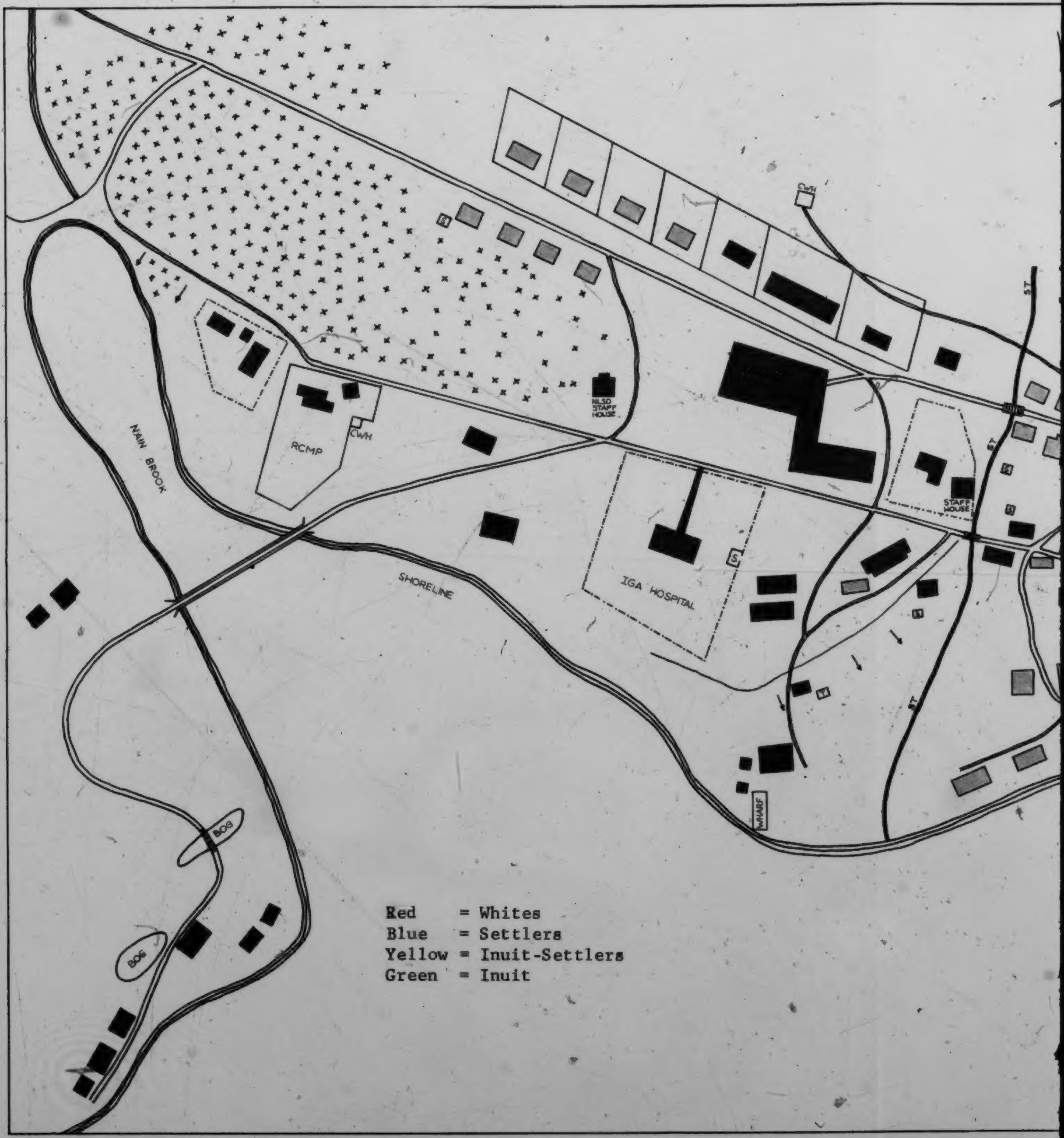
piilutok	"fits"
pillukok	"accidental cause"
piuŋnittumik killivuq	"serious cut"
puijukukiŋa	"seal finger"
puiliagiq	"rash"
piuŋillit	"severe sickness"
puiq	"pimple"
pullaaq	"colic"
pullaaminik puiŋalukjauq	"severe colic"
puvaluttuq	"tuberculosis"
qitssaqtuq	"withdrawal; from people"
qivitok	"ghost who cannot return home again; a hermit"
quajimmamijuq	"strange behaviour"
quaqssaq	"shock (psychological)"
qukiluk idilliq	"gun graze"
qukitausimajuq ikkiliq	"gun wound"
rhumatijuq	"rhumatism"
saalulisimuk	"thinness from aging"
saaluttuq	"thinness from childhood"
sagvilligiq	"influenza"
sauŋa nakasimajuq	"broken bone"
silamit	"environmental conditions"
sinnigunna iqattatuq	"insomnia"
siusigiq	"earache"

sivuguk	"covert apprehension"
tataminiak	"slight withdrawal; from people"
tatik	"faint"
tautuŋituq takuŋituq	"blind"
tatsakomagami	"birthmark"
tatsakuluk	"mole"
timiluttaq	"illness of the body"
tunnuillijuq	"damaged back"
tunnuanijuq idluilliŋajuq	"hunchback (kyphosis)"
tupik	"choke"
tupillituq	"severe choking"
tussaŋituq	"deaf"
uibjaaŋuq	"dizzy"
uimajaapok	"over-nervous, agitation"
unguk	"wart"
utasimajuq immataulugu	"blister (from burn)"

APPENDIX II

TAXONOMY OF ILLNESS

Innuillilluk sigisuit "Patterns of Malfunction"												
Adjijengillitisisut "Abnormal Conditions"								Pagvisautit "Annoyance Conditions"				
Jannimmaluk "Critical Sickness"				Inuilliniminit "Congenital"	Pillukok "Accident"		Silimit "Environment"	Jannimmuksaussaq "Potential Sickness"		Inuilliniminit "Congenital"	Pillukok "Accident"	Silimit "Environment"
Piungnillit "Serious Sickness"		Jannimmuksauluk "Warning Sickness"			Piungnillit, "Serious Sick"	Jannimmuksauluk "Warning"		Niaqulutaaq, "Head"	Timilutaaq, "Body"			
Niaqulutaaq "Head"	Timilutaaq "Body"	Niaqulutaaq "Head"	Timilutaaq "Body"									
Quajimmamijuq, "Strange Behaviour" Issumaitsissuq, "Mentally ill" Issumaqatsiannigituq, "Insanity"	Tokojuq, "Paralyzed" Puvalusik, "Tuberculosis" Pneumoniaaq, "Pneumonia" Omattilusik, "Heart disease" Akeaguluttaq "Serious stomach disorder"	Iuguksaaq, "Seeing Spirits" Quaqssaq, "Shock" Piilukok, "Fits" Sinnigunnaiqattatuq, "Insomnia" Qitssaqtuq, "Withdrawal"	Piatuqatsaeinatut, "Alcoholic" Sagvilligiq, "Influenza" Kinetdlilligik, "Tonsilitis" Mesilsi, "Measles" Aoungaingusiu ituq, "Poor circulation"	Tunnuanijuq idluillliajuq "Hunchback" Ittigaillusillok, "Clubfoot" Tautu ituqtaku ituq, "Blind" Tussa ituq, "Deaf" Oklagunnana ituq, "Mute"	Sau anakasimajuq, "Broken Bone" Piu nittumik killivuq, "Serious Cut" Kukitausimajuq, "gunshot wound" Puijikukinga "Seal finger"	Kimimut kijausimajuq, "dog bite" Idluilliq, "Sprain" Savimut kapitausimajuq, "Knife wound" Kukillok, "gun graze"	Illuiq, "Snowblind" Rhumatijuq, "rhumatism" Quasimajuq, "severe frost bite"	Uimajaapok, "Overt nervousness Sivuguk, "Covert nervousness" Ak, "Little fits" Tatik, "Faint" Tataminiak, "Slight withdrawal Niaqunguk, "Headache"	Ajuak, "Boil" Anagak, "Diarrhea" Anini itsaaq "short of breath" Kaaluk, "scabby sores" Naanguq, "Belly ache" Ipelua laaq, "profuse sweating" Nutsuksiqnukimik, "Pulled muscle" Puiliagiq, "rash" Nuvak, "Common Cold"	Tatsak omagami, "Birthmark" Kiluluttaq, "Harelip" Tunnuanijuq idluilliajuq "Hunchback"	Killiq, "Small cut" Iyenga tillugujauq, "Black eye" Kidssuq, "Scratch" Utasimajuq immataulugu "Blister from burn"	Ausikuugiak, "Pain while thawing" Olik, "Chills due to exposure" Pannituq Amik, "Chapped skin"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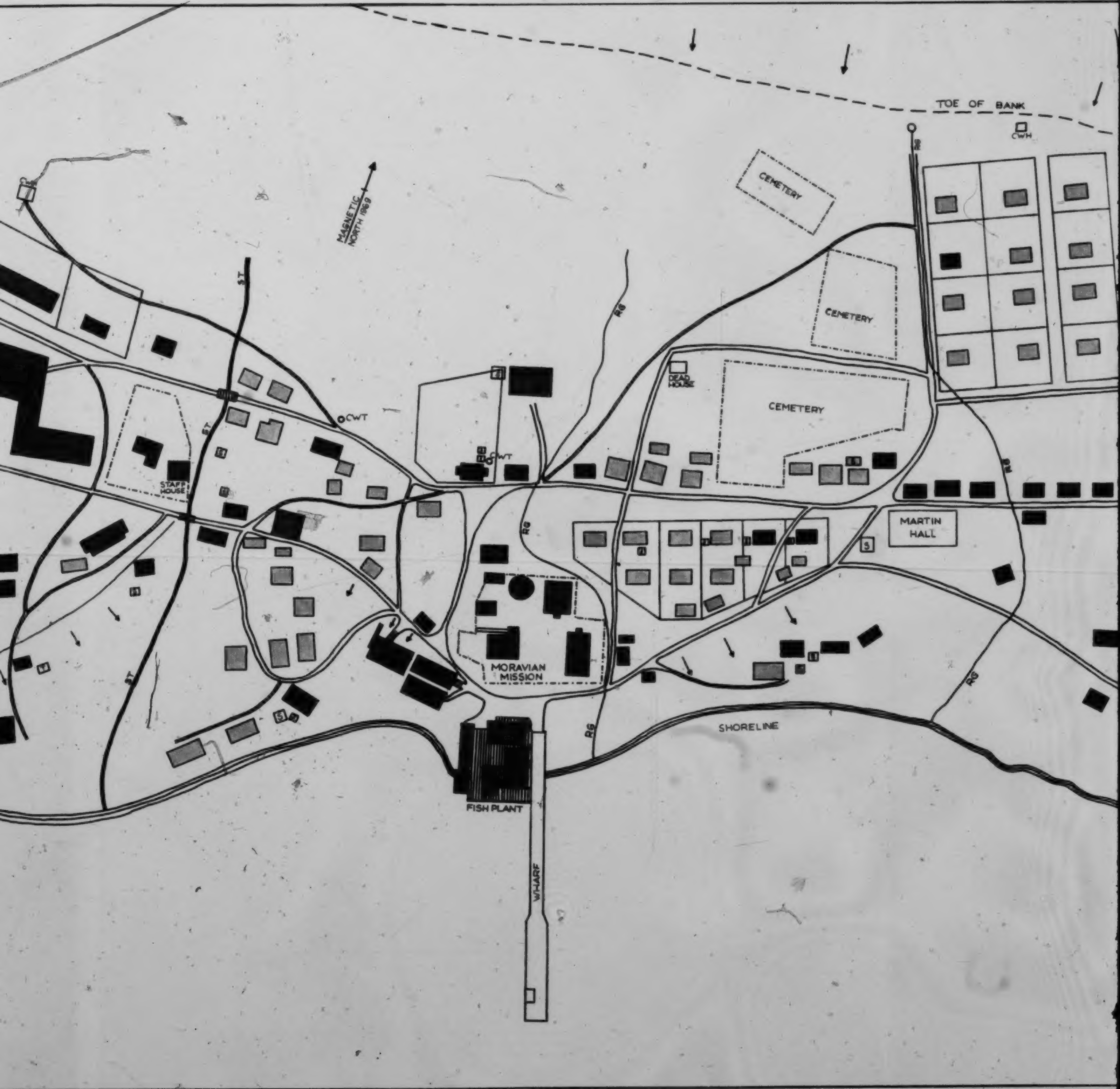
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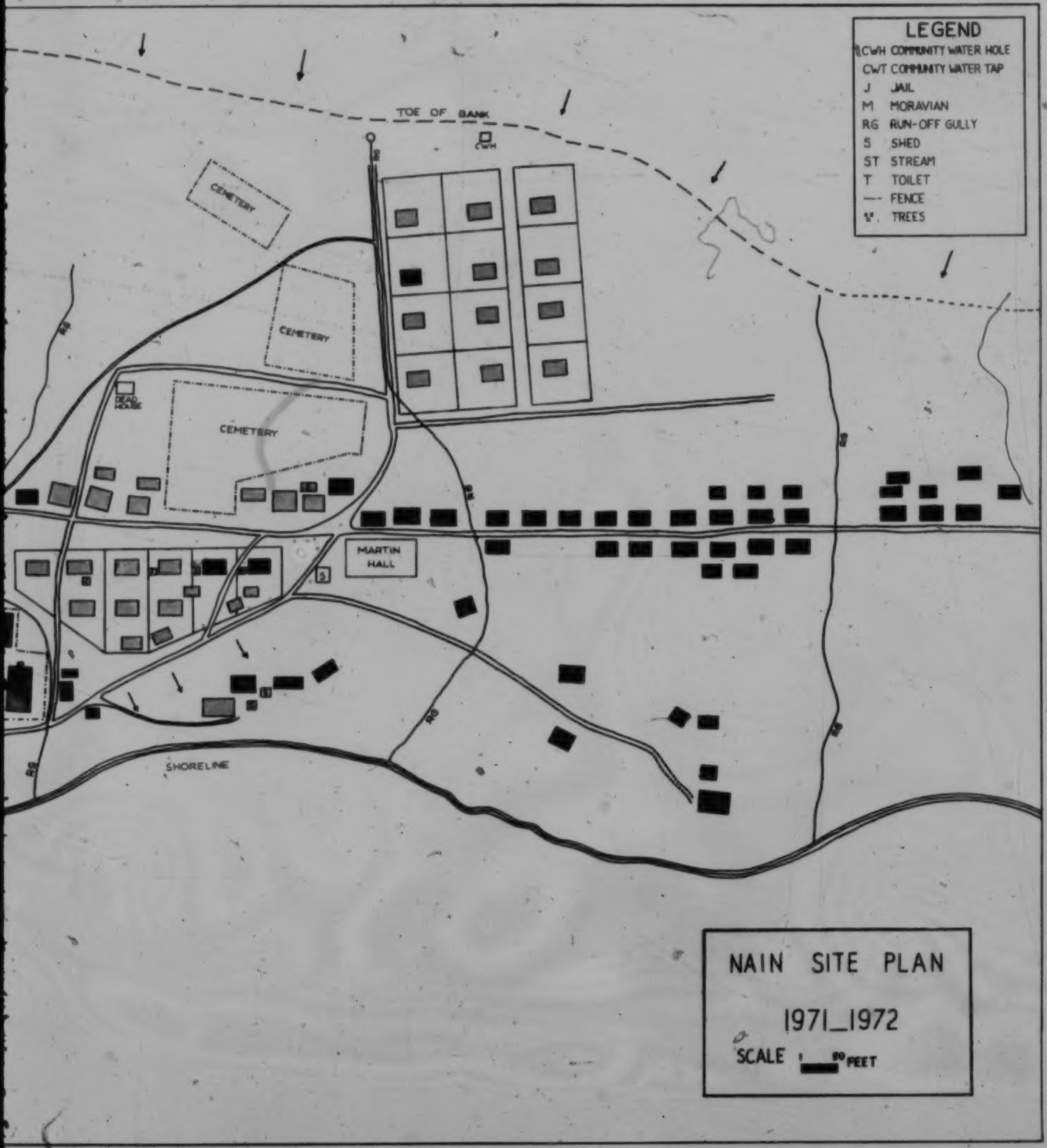
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